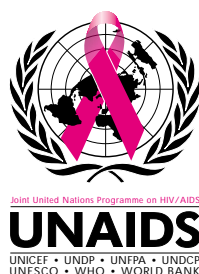


A human rights approach to AIDS prevention at work:

*The Southern African Development
Community's Code on HIV/AIDS
and Employment*



UNAIDS Best Practice Collection
KEY MATERIAL

Acknowledgements

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This work was done with the technical and financial support of UNAIDS. The positions expressed in the report are those of the author and are not intended as the official views of UNAIDS.

The author would like to acknowledge the following people who assisted with the research and drafting of this publication:
Helen Jackson and Russell Kerkhoven, Southern African AIDS Information Dissemination Service, Zimbabwe
Rene Loewenson, Organisation of African Trade Union Unity, Zimbabwe
Michaela Figueira, Legal Assistance Centre, Namibia
Lucy Hunter, Botswana Business Coalition on AIDS, Botswana
Miriam Maluwa, UNAIDS, Switzerland
Mazuwa Banda, UNAIDS, Zambia
Betsi Pendry, AIDS Law Project, South Africa
Cecilia Mulindeti, SADC Employment and Labour Sector, Zambia

All aspects of the publishing operation were coordinated by Andrea Verwohlt (UNAIDS, Information Centre, Geneva, Switzerland)

UNAIDS/00.06E (English original, June 2000)

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A human rights approach to AIDS prevention at work

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Community's Code on HIV/AIDS
and Employment



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Geneva, Switzerland
June 2000

“States should ensure that government and the private sector develop codes of conduct regarding HIV/AIDS issues that translate human rights principles into codes of professional responsibility and practice, with accompanying mechanisms to implement and enforce these codes.”

UN Guidelines on HIV/AIDS and Human Rights, 1998

United Nations
New York and Geneva, 1998

EXECUTIVE SUMMARY

In September 1997 the Council of the Southern African Development Community (SADC) unanimously approved a regional code on HIV/AIDS and Employment (hereafter called "the Code").

The intention of the Code is to create a regional standard on the best ways to manage AIDS in the employment setting. It aims to guide employers, employees and governments towards the most economically sustainable and humane ways to respond to HIV and AIDS in the workplace.

The SADC is the first regional intergovernmental organization in the world to take such an initiative. This publication documents the Code and examines the reasons why the SADC adopted it.

- ❑ Chapter 1 examines the state of the HIV/AIDS epidemic in southern Africa and its impact on the workforce.
- ❑ Chapter 2 traces the process that was undertaken by SADC, trade unions, business organizations, governments and nongovernmental organizations (NGOs) to promote the Code.
- ❑ Chapter 3 focuses on the principles underlying the Code and explains why the issue of a uniform response to AIDS and employment is important for southern Africa and other developing countries.
- ❑ Chapter 4 looks at some of the partnerships that were built and strategies that were adopted in several countries during the process. It illustrates how lobbying and advocacy have drawn HIV/AIDS more fully to the attention of trade unions, business and government.
- ❑ Chapter 5 looks at challenges for the effective implementation of the Code. It presents a number of ways in which employers, employees and governments can use the Code to introduce better activities around HIV and AIDS in the workplace.
- ❑ Finally, the appendices contain the SADC Code, the Namibian Code and the Zimbabwean Code. In addition there is a list of important publications in the references.

In every country the workplace is one important front for preventing new HIV infections and promoting nondiscrimination towards people with HIV/AIDS. It is hoped that this 'Best Practice' will serve several purposes. In countries where there have been no systematic activities around AIDS in the workplace we hope that it will be a guide on how to develop policy and build partnerships. For countries in southern Africa we hope that it will help carry forward the campaigns that have already started.

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Acronyms

AIDS	acquired immunodeficiency syndrome
BBCA	Botswana Business Coalition on AIDS
HIV	human immunodeficiency virus
ILO	International Labour Organization
NGO	nongovernmental organization
OATUU	Organisation of African Trade Union Unity
SADC-ELS	Southern African Development Community Employment and Labour Sector
SAfAIDS	Southern African AIDS Information Dissemination Service
SATUCC	Southern African Trade Union Coordinating Committee
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

Glossary of commonly used terms

Employee benefits: Pension funds, death benefits, medical assistance schemes: these benefits are usually paid as an addition to an employee's salary and are made up from a joint cash contribution from both the employer and the employee.

Epidemiology: The study of the incidence and distribution of diseases and of their control and prevention. For example, epidemiologists monitor HIV infection rates in different countries and use this information to help with HIV/AIDS prevention.

Formal sector employment: Employment in registered companies or in government. For example the mining industry, a clothing factory or a shop.

Informal sector employment: Self-employment, often in enterprises that are necessary for survival in countries where there is high unemployment. For example, the selling of vegetables or curios on pavement stalls, as well as sex work.

Fair discrimination: Treating someone differently according to fair criteria, such as their qualifications, experience or proven ability.

Unfair discrimination: Treating someone differently according to unfair or arbitrary criteria, such as their race, religion or HIV status.

Reasonable accommodation: Offering an employee an easier or less physically demanding job when that person becomes too ill to continue to carry out the original tasks for which they were employed. For example, offering an underground mineworker jobs on the surface. In some countries 'reasonable accommodation' is a legal requirement, before an employer can dismiss a person as a result of ill-health.

Tripartite negotiations: Negotiations or discussions between representatives from labour, business and government, the three major stakeholders in employment.

Universal precautions: A set of steps that can be taken to protect health care workers and others from being infected with bloodborne viruses such as HIV. This includes the use of latex gloves and procedures for cleaning up blood spills.

1 HIV/AIDS IN SOUTHERN AFRICA

1.1 The Southern African Development Community

The Southern African Development Community (SADC) was formed in 1992. Today SADC is an intergovernmental partnership of 14 countries – similar to the European Union (EU) or the Association of South East Asian Nations (ASEAN). It aims to unite the countries of southern Africa in a “Regional Economic Community” that will be a building block towards an African Economic Community. The current SADC members are:

Angola	Botswana	Democratic Republic of the Congo
Lesotho	Malawi	Mauritius
Mozambique	Namibia	Seychelles
South Africa	Swaziland	United Republic of Tanzania
Zambia	Zimbabwe	

SADC has a permanent secretariat that is located in Gaborone, the capital of Botswana. The Secretariat coordinates its work through various sectors, which are located in different countries.¹ The SADC Employment and Labour Sector is located in Zambia.² The Health Sector is based in South Africa.

Every year SADC holds an annual Summit with Heads of State or Government. This is the ultimate policy-making institution of SADC. Linked to this is a Council of Ministers which makes recommendations to the Summit and ensures that policies are properly implemented.

When the Southern African Development Community was established in 1992 HIV and AIDS was not considered to be an important issue by any of the governments of the southern African region. Sudden political developments had created the possibility for a united strategy against the region's twin evils, poverty and underdevelopment. Namibia had been independent since 1989 and in 1990 negotiations had started between the African National Congress and the National Party in South Africa that would lead to the ending of apartheid.

¹ The sectors are: Agriculture and Livestock Production; Natural Resources Research and Training; Culture and Information; Energy; Environment and Land Management; Finance and Investment; Food, Agriculture and Natural Resources; Human Resources Development; Industry and Trade: Inland Fisheries, Forestry and Wildlife; Livestock Production and Animal Disease Control; Marine Fisheries and Resources; Mining Employment and Labour; South African Centre for Co-operation in Agricultural Research; Southern African Transport and Communications Commission; Tourism; Water.

² The Employment and Labour Sector Coordinating Unit: P.O. Box 32186, Lusaka, Zambia. Tel: 260 1 235173/225751, Fax: 260 1 235172, E-mail: sadc-els@zamnet.zm

The founders of SADC hoped that the strengthening of political and economic unity across the region would help them to address these issues. Majority rule in South Africa would allow the most powerful economy in the region to be used to benefit all the people of South Africa – but also to give a boost to development in its neighbouring countries. Therefore, SADC was intended “to promote regional economic welfare, collective self-reliance and integration; in the spirit of equity and partnership.” Its ideals were “economic well-being, the improvement of the standard and quality of life, freedom and social justice, and peace and security, for the peoples of southern Africa.”³

At the time of SADC's formation in 1992 cases of human immunodeficiency virus (HIV) infection had been detected in all southern African countries, but very few people were concerned that it could reach epidemic proportions. Unfortunately, however, the terrible social conditions under which most people lived also contributed to placing millions of people at risk of infection with HIV.

1.2 Conditions that contribute to vulnerability to HIV infection in southern Africa

The meaning of 'vulnerability'

HIV does not discriminate between men and women, rich and poor, black or white. All people who are sexually active and who do not practise safe sex can be infected with HIV. However, the conditions under which some people live can put them at a greater risk than others. For example, people who are illiterate are more at risk because they cannot read printed messages about how to avoid infection with HIV. Women who are poor are more likely to sell sex than women who are rich and are therefore more likely to be infected with HIV. This is called vulnerability. People in developing countries are highly vulnerable to HIV.

Poverty

Southern Africa is one of the poorest regions of the world. The 14 member states of SADC have a population of 191 million people. In most countries the majority of people are illiterate and live below the poverty line. Millions live in rural areas – often without access to electricity, clean water or telephones (see Table 1 below).

³ Towards a Southern African Development Community – A Declaration made by Heads of State or Government of Southern Africa at Windhoek, Namibia, August 1992.

Table 1. Demographic indicators: Southern Africa

Demographic Indicators: Southern Africa				
	Population 1997 (thousands)	Average population growth rate (1995-2000)	Urban population (percentage)	Average life expectancy (1995)
Angola	11,600	3.3	32	47.4
Botswana	1,500	2.2	28	51.7
Dem. Rep. Congo	48,000	2.6	29	52.4
Lesotho	2,100	2.5	23	58.1
Malawi	10,100	2.5	14	41
Mauritius	1,100	1.1	41	70.9
Mozambique	18,300	2.5	34	46.3
Namibia	1,600	2.4	37	55.8
Seychelles	800	n.a.	n.a.	72
South Africa	43,300	2.2	51	64.1
Swaziland	900	n.a.	n.a.	58.8
U.R. Tanzania	31,500	2.3	24	50.6
Zambia	8,500	2.5	43	42.7
Zimbabwe	11,700	2.2	32	48.9
Total	191,000			
Average		2.4	32	63.4

(Sources: Population Division, Department of Economic and Social Affairs, United Nations Secretariat; UNFPA)

Migration

There is large-scale migration of people between countries and from rural areas to the cities. The constant moving and mixing of populations is often related to employment or to the need to find work to survive. Once people arrive at the cities they live in huge informal settlements or 'squatter camps' in conditions of deprivation that are very similar to those in rural areas.

Migrant labour is still a feature of formal sector employment. Nearly half of the workforce on South Africa's gold mines comes from the neighbouring countries of Lesotho, Botswana and Mozambique.⁴

⁴ UNDP, *HIV/AIDS and Human Development, South Africa*, 1998, p. 77.

Ironically, peace across most of the subcontinent has also created additional vulnerability to HIV infection among many workers and their families. There has been an improvement in communications and trade. New roads such as the 'Maputo corridor', will soon make it possible for goods to be carried by truck from the west coast of southern Africa (Windhoek in Namibia) to the east coast (Maputo in Mozambique).

Poverty and high unemployment have created large informal production and trading sectors. Tens of thousands of people from Zimbabwe, Malawi and Mozambique travel long distances by train and road to relatively "prosperous" countries like South Africa to sell woodcarvings, traditional cloths and African curios to tourists, or to try to find employment. In South Africa it has been estimated that there are between 500 000 and 1.5 million undocumented or "illegal" immigrants.⁵

HIV and migration

Large-scale legal and illegal (undocumented) migration makes it more difficult to combat HIV transmission and adds to vulnerability. Migrants who are looking for work or escaping political conflicts are often alone and far from their families. They are likely to sell sex or to pay for sex either to make money or for pleasure. Illegal immigrants, who are afraid of being caught, are usually afraid to use health services. Victims of rape will not report to the police for fear of being deported. However, stricter measures to keep borders closed will not work because migration is driven by poverty. HIV prevention therefore creates a further need for additional cooperation and common strategies on migration and regional development.

Political conflicts and wars

Most of the SADC region is at peace, but there are ongoing civil wars in Angola and the Democratic Republic of the Congo. These wars are creating large internal refugee populations and movements of people between countries.

Refugees are vulnerable to HIV for the same reasons as migrants (see above). In addition they are often traumatized by war and violence. In such conditions social norms break down. In refugee communities there is increased rape and violence against women and children; there is almost no access to health services. Finally, in the face of personal upheaval the risk of HIV infection appears to be a minor concern.

Culture and tradition

Many people in African societies still respect traditions and cultural practices that increase individual vulnerability to HIV. For example:

- ❑ the practice of mandatory wife inheritance by a brother if a woman's spouse dies;
- ❑ the 'cleansing' of virgins on reaching puberty through having forced sex with a disguised male;
- ❑ the minority status of women under customary laws and unequal educational opportunity for the girl child.

⁵ Human Rights Watch, *"Prohibited Persons": Abuse of Undocumented Migrants, Asylum Seekers and Refugees in South Africa*, 1998.

All of the factors listed above create vulnerability to HIV infection. Some have no direct relationship with employment. But the implementation of creative employment strategies can address all of these issues. For example:

- ❑ workplace AIDS education can sensitively raise awareness about cultural practices that contribute to HIV;
- ❑ employers and employees can change workplace policies that require workers to travel far from home without their families. In Zimbabwe a successful intervention programme was developed in the transport sector. In a joint effort between managers and workers through the National Employment Council for the transport industry, a peer education programme was developed and funded, to reach drivers and communities where long-haul drivers stopped en route.⁶

Strategies such as these help to mitigate the worst impact of AIDS. The SADC Code on AIDS and Employment recognizes this.

To tackle all these problems, African leaders such as Presidents Nelson Mandela of South Africa and Yoweri Museveni of Uganda have become advocates of an 'African Renaissance'. They hope that it will be possible to extend development to the rest of the continent from countries such as South Africa, Botswana, Mozambique and Uganda where there is economic growth. Eventually, they argue, these countries will lead a 'renaissance' that will witness Africa emerge as a major economic, cultural and scientific centre in the 21st century. However, as President Museveni has recognized, confronting the AIDS epidemic must be made a central part of economic regeneration.

1.3 The state of the HIV/AIDS epidemic in southern Africa

The AIDS epidemic is a major obstacle to be confronted in Africa's aspirations for sustainable economic growth and development.

By 1999 there were more people in southern Africa infected with HIV than in Europe, North and South America combined. An estimated four million adults and children have died and in coming years many more will die. Over 10 million people in southern Africa are infected with HIV (see Table 2).

⁶ *AIDS Analysis Africa (Southern Africa Edition)*, 8:2, 1997, p. 11; see also R Loewenson et al, *Best Practices: Company Actions on HIV/AIDS in Southern Africa*, OATUU, Harare, Zimbabwe 1999.

Table 2. HIV/AIDS statistics for southern Africa, 1997

HIV/AIDS Statistics for southern Africa 1997						
	People living with HIV (adults & children)	Average prevalence adult rates (adult pop., %)	Children living with HIV	Estimated AIDS cases	AIDS deaths (cumulative)	Orphans
Angola	110,000	2.12	5,200	28,000	25,000	19,000
Botswana	190,000	25.10	7,300	50,000	43,000	28,000
Dem. Rep. Congo	950,000	4.35	49,000	510,000	470,000	410,000
Lesotho	85,000	8.35	3,000	17,000	15,000	9,500
Malawi	710,000	14.92	42,000	480,000	450,000	360,000
Mauritius	500	0.08	n.a.	n.a.	n.a.	n.a.
Mozambique	1,200,000	14.17	54,000	290,000	250,000	170,000
Namibia	150,000	19.94	5,000	16,000	14,000	7,800
Seychelles	n.a.	n.a.	2,800	16,000	n.a.	n.a.
South Africa	2,900,000	12.91	80,000	420,000	360,000	200,000
Swaziland	84,000	18.50	n.a.	n.a.	14,000	8,000
U.R. Tanzania	1,400,000	9.42	68,000	1,000,000	940,000	730,000
Zambia	770,000	19.07	41,000	630,000	590,000	470,000
Zimbabwe	1,500,000	25.84	57,000	650,000	590,000	450,000
Total	10,049,500	Av. 12%	414,300	4,107,000	3,761,000	2,862,300

(Source: UNAIDS/WHO, 1998, *Report on the Global HIV/AIDS Epidemic*)

Despite the shockingly high HIV prevalence in most southern African countries the HIV/AIDS epidemic is still growing. In 1992, when SADC was launched, adult HIV prevalence across most of the region was under 5%. By 1999, in cities and towns across the region, it averaged close to 20%:

- In 1997 in Francistown and Gaborone, the two largest cities in Botswana, HIV prevalence amongst women antenatal attendees was 42.9% and 34.0%, respectively.⁷
- In 1995 in Harare, Zimbabwe's capital city, it was 37%, and 30% in the second largest city, Bulawayo.⁸

⁷ *AIDS Update*, AIDS/STD Unit, Ministry of Health, Botswana, January 1998.

⁸ Antenatal statistics provided by SFAIDS, Zimbabwe.

- ❑ In Namibia, by 1996, AIDS had become the largest cause of reported deaths, and national HIV prevalence was estimated to be 15.4%.⁹
- ❑ In 1996 in Blantyre, the largest city in Malawi, HIV prevalence at urban antenatal clinics was 34%.¹⁰
- ❑ In 1998 in three of the most industrialized provinces in South Africa (Gauteng, Kwa-Zulu Natal and Mpumalanga) adult HIV infection rates were over 20%.¹¹

1.4 The impact of AIDS on employees

In 1997 the President of South Africa, Nelson Mandela, told the World Economic Forum:

*"The severity of the economic impact of the disease is directly related to the fact that most of the infected persons are in the peak productive and reproductive age groups. AIDS kills those on whom society relies to grow the crops, work in the mines and factories, run the schools and hospitals and govern nations and countries"*¹²

HIV is mainly infecting and affecting people of working age. Most infected people are aged between 16 and 35. Depending on the baseline mortality in a country and the extent of HIV infection, the World Bank estimates that as a result of AIDS, deaths of "prime-age working adults" will rise by a multiple of 2 to 10.¹³ UNAIDS and the World Health Organization (WHO) have warned that:

*"in an area where overall HIV prevalence is 8%, HIV accounts for four out of five deaths between the ages of 25 and 34."*¹⁴

The impact of AIDS on the formal employment sector

The implications of these facts for the workplace are grave. The consequences of AIDS for a country's economically active age group are evident from what follows:

- ❑ In the United Republic of Tanzania it has been projected that adult deaths will reduce the labour force by 20% and the mean age of workers from 32 to 28 by 2010.¹⁵
- ❑ In Botswana, Malawi, Zimbabwe and Zambia life expectancy has declined dra-

⁹ UNDP, *Namibia Human Development Report 1997*, Windhoek 1998.

¹⁰ *AIDS Analysis Africa (Southern Africa Edition)*, 8:4, Dec 97/Jan 98, 5-7.

¹¹ *South Africa: Results of the Ninth Survey of Women attending antenatal clinics in the public health sector*, March 1999.

¹² President of South Africa, Nelson Mandela, Davos, Switzerland, 1997. Speech reprinted in *AIDS Analysis Africa (Southern Africa Edition)*, 7:5, 1997.

¹³ World Bank Policy Research Report, *Confronting AIDS, Public Priorities in a Global Epidemic*, 1997, Box 1.4, p.35.

¹⁴ *Report on the Global HIV/AIDS Epidemic*, WHO/UNAIDS, Geneva, 1998.

¹⁵ ILO EAMAT Working paper 3, *The Impact of HIV/AIDS on the Productive Labour Force in Tanzania*, 1995. Quoted in Loewenson R & Whiteside A, *HIV and AIDS in Southern Africa*, Whiteside (ed) *Implications of AIDS for Demography and Policy in Southern Africa*, University of Natal Press, 1998, p. 21.

matically. The US Bureau of Census projects that by 2010 in these and other countries life expectancy will have declined by 20% due to HIV/AIDS.¹⁶

A decrease in life expectancy and an increase in adult and infant mortality will change the face of the labour market. This is not just something that might happen in the future. It is already happening. In a range of professions, regardless of sector and size, there are signs of an increase in illness and death amongst the workforce:

- In southern Africa the mining industry employs between 750 000 and 900 000 people. Some mining companies estimate that up to 40% of their employees have HIV.¹⁷ Although the numbers of reported AIDS cases in the mines are still below 5% of the workforce, this will rise in the years ahead. In South Africa some projections suggest that within 10 years up to 25 000 mineworkers will die every year as a result of AIDS-related illnesses. AIDS will increase worker turnover by 3-6% per annum.¹⁸
- AIDS has created new direct costs for the mining industry. It also carries a huge social cost for the dependants of mineworkers who die and will no longer receive wage remittances. Six million people rely on mining for their livelihood.¹⁹ Deaths of the principal wage earner will result in increasing numbers of children having to work to compensate for parents who have died or who are too ill to work.
- In Botswana it is presently estimated that 33% of employee deaths are due to AIDS. Between 1996 and 2004 the expected annual adult death rate due to AIDS will rise from 4 per 1000 to 28 per 1000 (seven times).²⁰

These and other indicators of the impact of AIDS are drawn from medium-sized and large companies that have greater capacity to absorb the new costs and replace lost labour. In the formal sector HIV and AIDS will lead to declines in productivity due to lost time and absenteeism, increases in staff turnover, skills shortages and staff demoralization.

The impact of AIDS on the small and informal sector

Southern Africa also has a large micro or informal employment sector. Although this sector's contribution to traditional economic indicators such as Gross Domestic Product (GDP) is difficult to measure, this form of employment prevents millions of people from starving. This sector includes informal traders, peasant agriculturalists and women working in households.

¹⁶ Ibid, L Fransen, *HIV in Developing Countries*, p. 8.

¹⁷ OATUU, *Regional Consultation on HIV/AIDS Interventions in the Mining Sector in Southern Africa, Summary Report*, Harare, July 1998, p.5.

¹⁸ These projections have been produced by the Epidemiology Research Unit, a tripartite research body in South Africa, governed by the Chamber of Mines, the Department of Health and various Mineworkers' Unions. See also "Beyond the Bio-Medical and Behavioral: Towards an Integrated Approach to HIV Prevention in the Southern African Mining Industry", C Campbell and Brian Williams, *Social Science and Medicine*, in press.

¹⁹ T Devlin "Critical Issues Surrounding the Current and Future Impact of the HIV/AIDS epidemic and Employee Benefits", Paper presented at World Bank/ Chamber of Mines Southern African Regional Seminar on HIV/AIDS in the Mining Sector, 1995.

²⁰ Botswana National Task Force on AIDS at the Workplace, *Impact of HIV/AIDS and Options for Intervention: Results of a Five Company Pilot Study*, August 1997.

Governments and formal sector employers cannot afford to be complacent about the impact of AIDS on the informal sector. In many countries industrial and economic policy attaches great importance to encouraging small and micro employment enterprises. Even in the most industrialized countries of the region, such as South Africa, small employment enterprises employ millions of people.

The small and informal sector in South Africa

In South Africa 37% of private sector enterprises employ less than 50 people. They account for 20% of all those employed (see Table 3).

Table 3. The small and informal employment sector in South Africa²¹

Number of employees by sector			
	0-50	Medium	Large
Agriculture	746 400	240 600	308 000
Retail trade	795 000	64 000	261 000
Transport	144 600	21 000	66 000

Number of enterprises by sector & size			
	0-50	Medium	Large
Agriculture	87 200	3 600	1 400
Retail trade	317 200	950	733
Transport	49 500	280	227

The small size of these 'employers' makes it much more difficult to replace skilled and semi-skilled employees, for example motor mechanics, when they die or become too ill to work. Microenterprises will, therefore, find it far more difficult to absorb the costs of increased absenteeism, staff-turnover and death.

1.5 The impact of AIDS on the economy

Governments and employers must not draw comfort from suggestions that the net impact of AIDS on economic growth, particularly per capita Gross Domestic Product (GDP), might be small. Many traditional economic indicators do not provide an accurate picture of the actual impact of AIDS on either employers or employees. For example, as the World Bank report explains, the deaths of a large number of people in the low-income brackets and smaller numbers of high earners could even result in an overall increase in per capita GDP. In reality, though, overall well-being will not have improved and the incomes of survivors will have been reduced.²²

²¹ These statistics are drawn from information compiled in: *The state of Small Business in South Africa*, Ntsika and the Department of Trade and Industry (2nd edition, 1997).

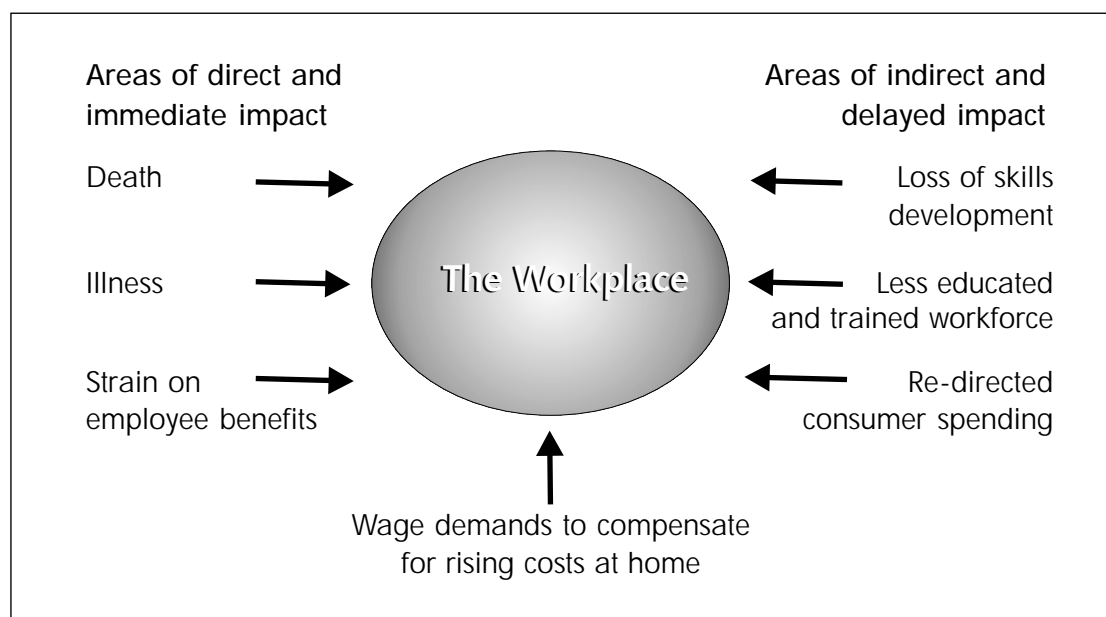
²² World Bank, *Confronting AIDS*, pp 32-33.

HIV and AIDS have grave consequences for human and social development. These factors will impact greatly on a country's ability to raise productivity and private and public investment:

For example:

- ❑ Many employees will have children and spouses who are also infected.
- ❑ The death of one or both parents will mean that young people will be forced to go to work earlier – sacrificing their education.
- ❑ The sustainability of economic growth in countries like Botswana and South Africa will be threatened in a shrinking consumer market that could result from declines in population growth and the re-direction of consumer expenditure into caring for those who are ill.
- ❑ AIDS will dramatically affect the social environment in which all businesses operate, even if 'costs' can be contained. AIDS will have an impact on the morale of populations in the same way, for example, that rampant crime has visibly affected the morale of citizens in South Africa.

Figure 1. The present and future impact of AIDS on the workplace



These facts are now a part of the business environment in southern Africa as well as in other developing regions of the world. They emphasize the importance of local, national and regional interventions that will help to prevent the continued rapid spread of HIV.

Employers, governments and trade unions must understand that a future beyond high AIDS-related morbidity and mortality does exist – but only if they act decisively now.

2 THE NEED FOR A SOUTHERN AFRICAN GUIDELINE ON HIV/AIDS AND EMPLOYMENT

2.1 The first call for a regional code

One of the objectives of SADC is to facilitate regional economic integration and to standardize labour market policies and practices. This requires a careful analysis of the effect that AIDS will have on the region's workforce and economies. Elements of such an analysis were provided in Chapter 1. Chapter 2 looks at the process that was involved in the development of the Code.

The SADC Employment and Labour Sector was formed in 1995. Since it was established it has set an example for other SADC sectors by operating in a way that has made it accessible to the views of trade unions, nongovernmental organizations and businesses. Commendably, it also recognized the importance of strategies to combat AIDS.

Its objectives are:

- ❑ To ensure that the Sector retains the tripartite relationship between labour, employers and government;
- ❑ To promote the formulation and integration of legal, economic and social policies and programmes which contribute to the generation of productive employment opportunities and income;
- ❑ To promote labour policies and measures which facilitate free labour mobility, remove distortion in the labour markets, enhance industrial harmony and increase productivity;
- ❑ To provide a framework for regional cooperation in the area of employment and labour with the full participation and involvement of all the social partners;
- ❑ To promote a framework for regional cooperation in the collection and dissemination of labour market information;
- ❑ To standardize social security schemes;
- ❑ To harmonize regulations relating to health and safety standards at workplaces across the region;
- ❑ To promote the development of institutional capacities as well as vocational and technical skills across the region.²³

All of these objectives will be directly affected by HIV/AIDS. All of these objectives emphasize the importance of the Sector's activities in developing a Regional Code on AIDS and Employment.

²³ *Southern African Development Community Sub-sector on Employment and Labour, Objectives, Terms of Reference, Institutional Structures, Policies and Strategies*, paper presented at the Workshop for the Development of a Regional Code on AIDS and Employment, C L Nyimba, 1996.

In November 1994 the first proposal to develop a southern African 'Code on AIDS and Employment' was made at a regional conference in Harare, the capital of Zimbabwe.²⁴

This conference brought together 70 participants from governments, nongovernmental organizations (NGOs), employer and labour organizations across the region. It explored a range of issues relating to AIDS, economic policy and employment.

In one of its resolutions the Conference noted the absence of policy guidelines about how to manage the effect and impact of HIV/AIDS on employment and economic development.

The resolution warned that:

*"HIV will cost southern African economies in terms of lost skills, lost production, a reduced tax base, increased social and health cost, reduction in household, company and national savings and increased consumption needs. The real costs of HIV/AIDS are poorly documented, not included in government budgets or estimates, or included as health costs despite their cross cutting economic / employment impact and thus sectoralised to the health sector."*²⁵

Delegates therefore proposed to exchange experiences and strategies for managing the impact of AIDS and felt that a regional code on AIDS and employment would assist this and potentially serve two important functions:

- as a policy framework and guideline;
- as an entry point for a wider review of regional issues relating to AIDS and employment and for a better exchange of information about the impact of AIDS on the labour market between SADC members.

A proposal for the drafting of a regional code was therefore made by the Secretary General of the Southern African Trade Union Coordinating Committee (SATUCC) and it was agreed that:

*"Southern African countries [should] develop and legislate national codes of practice on AIDS and employment through a tripartite process with other affected communities involved."*²⁶

Following the Regional Conference on AIDS and Employment the Southern African Labour Commission (the predecessor of the SADC Employment and Labour Sector) supported the recommendations. It proposed that national policies and programmes on HIV/AIDS and its impact on the workforce, productivity and the economy should be formulated through a process of tripartite consultations.²⁷ In February 1995 the International Labour Organization (ILO) was asked to assist southern African countries to devise a process that would lead to the drafting of a regional code.

²⁴ The Southern African Conference on AIDS and Employment was hosted jointly by the Organisation of African Trade Union Unity Health, Safety and Environment Programme (OATUU-HSEP) and the Southern African AIDS Information Dissemination Service (SAfAIDS), a nongovernmental organization.

²⁵ Conference report, 1994.

²⁶ Ibid. In southern Africa 'tripartite' refers to collaboration between the main role-players in the economy: business, labour and government.

²⁷ Sixteenth Ministerial and Tripartite meeting of the SALC, February 1995.

2.2 Drafting the first regional code

In Zimbabwe in January 1996 the Organisation of African Trade Union Unity (OATUU) and the ILO organized a joint workshop with tripartite representatives from the five southern African countries that had already started to develop national employment codes – Botswana, Namibia, South Africa, Zambia and Zimbabwe. The objective was to merge their experiences into a regional document.

The ‘Mazvikadei Workshop’ was opened by Zimbabwe’s Minister of Public Service, Labour and Social Welfare, who said:

“The implications of the AIDS epidemic should not lead to despair, but rather should galvanize all social partners and sectors to optimum efforts for HIV risk prevention and plan for challenges ahead. The impact of AIDS will be reduced by collaborative planning and programming as well as promulgating supportive legislation...”²⁸

At the ‘Mazvikadei Workshop’ support for a regional standard did not come automatically. Delegates debated the principles that needed to be included in a regional code and initially there was disagreement on certain issues, including:

- ❑ whether pre-employment or pre-training HIV screening was justifiable.
- ❑ whether it was permissible to test expatriate (foreign) workers for HIV. For example, although the National AIDS Plan in Botswana opposes mandatory testing of local employees an exception is made for foreign people who are seeking to work in Botswana.²⁹

Some of these issues were referred back to national tripartite bodies for further discussion. Other issues were resolved at the workshop. On HIV testing, for example, it was agreed by everyone that pre-employment HIV testing is not acceptable, but representatives of business argued that in a small number of cases where an employee is being sent on a costly training course there may be some justification for HIV testing. Therefore it was agreed that the Code should state that “in general there should be no compulsory testing for HIV.” Overall however there was enough will to reach agreement and produce a draft Code on which consensus was reached.

At the ‘Mazvikadei Workshop’ the SADC representative made a commitment that the Code would be officially tabled at the next meeting of the SADC Employment and Labour Sector, in May 1996. At this meeting, which was held in Lilongwe, Malawi, the Code was supported by officials from labour ministries across the region. Nonetheless, the SADC Ministers of Labour felt that there had not been enough discussion of the Code at a national level by business, trade unions and governments. The draft Code was therefore referred back to the SADC member countries for further discussion. Meanwhile SADC undertook to carry out additional research to examine the impact that AIDS was going to have on employment in the region. The next discussion of the Code was scheduled for a year later.³⁰

²⁸ Workshop Report, the Southern African Tripartite Workshop on AIDS and Employment, Mazvikadei, Zimbabwe, 1996.

²⁹ Botswana National Policy on HIV/AIDS, Ministry of Health, 1993.

³⁰ Resolution of SADC Employment and Labour Sector meeting, May 1996.

2.3 Adoption of the Code by the SADC summit

Between May 1996 and May 1997 advocacy for the Code continued. Lobbying was led by OATUU and by some NGOs. The first draft of the SADC Code was widely distributed through networks of AIDS service organizations, trade union federations and government bodies.³¹

In December 1996 a Joint SADC/European Union Conference on Regional Approaches to the HIV/AIDS Epidemic took place in Lilongwe, Malawi. This conference looked at the impact that AIDS was likely to have on a range of issues, including employment, education, tourism and trade. It too resolved that a regional code on AIDS and employment was needed.³²

During 1996 national tripartite discussions on the Code took place in many SADC countries. When the Code was again presented to the SADC Employment and Labour sector in May 1997 it was agreed that there had now been sufficient consultation. The Code was then tabled at a meeting of Ministers of Labour from all the SADC countries (except Angola) that was held in Pretoria, South Africa, where it was overwhelmingly endorsed. It was forwarded to the SADC Summit in September 1997 for final ratification. At this meeting the Code was approved by Heads of Government as a new regional standard.

The SADC Code on AIDS and Employment is intended to influence labour policy practice in all fourteen of SADC's member countries. It is not a legally binding treaty or an instrument of law. However, the Code recommends that "SADC member states develop tripartite national codes ... that shall be reflected in law." During 1998 two countries, Namibia and Zimbabwe, introduced a version of the Code into their labour legislation.

Namibia

In Namibia Guidelines for the Implementation of a National Code on HIV/AIDS and Employment were published in a Government Gazette in April 1998.³³ In terms of the Namibian Labour Act the Code contains "guidelines and instructions to be followed and adhered to by all employers and employees."

Zimbabwe

In Zimbabwe the national Code on AIDS and Employment was passed by parliament in 1998 as Labour Relations (HIV and AIDS) Regulations under the Labour Act.³⁴ The code covers in a comprehensive manner: provisions for education of employees on HIV/AIDS; prohibition against HIV testing on recruitment; statements against discrimination on the grounds of HIV status in promotion, transfer, job status, benefits or training; entitlement to sick or compassionate leave; provision of safe working environments where HIV exists; and display of the Code in all workplaces.

To ensure that other countries follow the example of Zimbabwe and Namibia, SADC has been mandated to set up a mechanism for monitoring the Code's implementation and enforcement through national law.

³¹ In Chapter 4 the support given by NGOs and trade unions to the Code is examined in greater detail.

³² *Report and Resolutions of the Joint SADC/European Union Conference on Regional Approaches to the HIV/AIDS Epidemic*, Malawi, December 1996.

³³ Government Gazette of the Republic of Namibia, Guidelines for the Implementation of a National Code on HIV/AIDS in Employment, April 1998, see Appendix B.

³⁴ Statutory Instrument 202, 1998, see Appendix C.

3 PRINCIPLES AND POLICY COMPONENTS OF THE REGIONAL CODE

The contribution that can be made to HIV/AIDS prevention at work and outside work by trade unions and employer organizations is recognized in national AIDS policies and plans. The workplace has a large part to play in society's efforts to control the AIDS epidemic. First and foremost, workplaces can be turned into 'adult class rooms' that teach millions of employees about HIV. In this Chapter we look at the principles on which the Code is based and the recommendations it makes concerning workplace policy.

Decades of institutionalized racism and colonialism left most of the southern African region underdeveloped and impoverished. Today there are huge social and economic disparities within countries and between countries. For example, South Africa is considered a 'middle-income country'. In 1998 it was ranked 89th on the Human Development Index (HDI). However within South Africa there remains enormous poverty and inequality. Malawi (161st on the HDI) and Mozambique (166th on the HDI) are among the poorest countries in the world.³⁵

In the 1980s and 1990s, political freedom for people in southern Africa presented many new social and economic challenges. The question of how to achieve sustainable social development became particularly important.

It is here that the prerogatives of economic development and effective HIV prevention now coincide: managing the impact of the AIDS pandemic will be one of the greatest economic challenges southern Africa will have to face.

3.1 Three key principles of the Code

Human Rights

- ❑ The Code is based on "the fundamental principles of human rights... World Health Organization and International Labour Organization regional standards and Guidelines".

In southern Africa the reaction to AIDS in the workplace has repeated what has happened in many other parts of the world. Trade unions and NGOs have documented how the response of many employers (large and small) is to resort to acts of unfair discrimination.³⁶

- ❑ Some employers implement mandatory testing of job applicants for HIV. People with HIV are then refused work.
- ❑ Some companies dismiss workers with AIDS or only employ those who they think have a 'low risk' of being infected with HIV.³⁷

³⁵ UNDP, *Human Development Report*, 1998.

³⁶ See: M Heywood, *Human Rights Violations of People With HIV/AIDS: The Implications for Equitable Development in South Africa*, research paper for the UNDP Human Development Report, South Africa, 1998. Available at www.hri.ca/partners/alp/.

³⁷ See: UNDP, *HIV/AIDS and Human Development, South Africa*, 1998.

- ❑ Many company medical insurance schemes exclude HIV from their medical benefits.
- ❑ Some industries have proposed a major restructuring of employee benefits to try and cut out the anticipated cost of HIV and AIDS.

Unfair discrimination is contrary to the principles of the Universal Declaration of Human Rights. Many of the practices described above erode people's rights to fair labour practices and equality of opportunity. They are in conflict with International Conventions and Treaties on Human Rights that most SADC Governments have ratified and pledged "to respect, protect, promote and fulfill". For example, employers who refuse to train or employ people with HIV are acting in violation of the International Covenant on Economic, Social and Cultural Rights, which has been ratified by all the SADC member states, except Botswana, Swaziland and South Africa. This is because their actions will be denying large numbers of people:

"the right to work, which includes the right of everyone to the opportunity to gain his living by work which he freely chooses or accepts."³⁸

Unfair discrimination is also clearly against principles for the management of HIV and AIDS in the Workplace that have been suggested by the International Labour Organization and World Health Organization. As long ago as 1988 a consensus statement issued by the ILO and WHO suggested that:

"Concern about the spread of HIV/AIDS provides an opportunity to re-examine the workplace environment. It provides an opportunity to create an atmosphere conducive to caring for and promoting the health of all workers. This may involve a range of issues and concerns, not only individual behaviour, but also address collective responsibility. It provides an opportunity to re-examine working relationships in a way that promotes human rights and dignity, ensures freedom from discrimination and stigmatization, and improves working practices and procedures."³⁹

³⁸ International Covenant on Economic, Social and Cultural Rights, Article 6 requires governments to "take appropriate measures to safeguard this right." Article 7 also recognizes "the rights of everyone to just and favourable conditions of work" and to "equal opportunity for everyone to be promoted in his employment .. subject to no conditions other than seniority and competence."

³⁹ WHO/ILO Consensus Statement on AIDS and the Workplace, in Global Programme on AIDS, *Report of the Consultation on AIDS and the Workplace*, June 1988, p. 9; see also WHO AIDS Series, 7, *Guidelines on AIDS and First Aid in the Workplace*, 1990.

UN International Guidelines on HIV/AIDS and Human Rights

In recognition of the individual's human rights, health and economic effects of workplace discrimination the United Nations' *International Guidelines on HIV/AIDS and Human Rights* also contain a series of recommendations relating specifically to employment. In a Guideline on 'Anti-discrimination and Protective Laws' the United Nations proposes that:

"Laws regulations and collective agreements should be enacted so as to guarantee the following workplace rights:

- ❑ A national policy on HIV/AIDS in the workplace agreed upon in a tripartite body;
- ❑ Freedom from HIV screening for employment, promotion, training or benefits;
- ❑ Confidentiality regarding all medical information, including HIV/AIDS status;
- ❑ Employment security for workers living with HIV until they are no longer able to work, including reasonable alternative working arrangements;
- ❑ Defined safe practices for first aid and adequately equipped first aid kits;
- ❑ Protection for social security and other benefits for workers living with HIV, including life insurance, pension, health insurance, termination and death benefits;
- ❑ Adequate health care accessible in or near the workplace;
- ❑ Adequate supplies of condoms available free to workers at the workplace;
- ❑ Workers' participation in decision-making on workplace issues related to HIV/AIDS;
- ❑ Access to information and education programmes on HIV/AIDS, as well as to relevant counselling and appropriate referral;
- ❑ Protection from stigmatization and discrimination by colleagues, unions, employers and clients;
- ❑ Appropriate inclusion in workers' compensation legislation of the occupational transmission of HIV (e.g. needlestick injuries), addressing such matters as the long latency period of infection, testing, counselling and confidentiality."⁴⁰

When confronting AIDS it is important to learn from human rights violations of the recent past. If governments and employers stigmatize those who are infected and or affected they will perpetuate the social problems that have arisen as a result of racism. The negative consequences of discrimination against black people and discrimination against people with HIV/AIDS for economic growth and development are potentially very similar.

⁴⁰ Office of the High Commissioner for Human Rights (OHCHR)/UNAIDS, *International Guidelines on HIV/AIDS and Human Rights*, 1997, Guideline 5, p. 14-15.

Sustainable development depends upon harnessing the skills and energies of as many people as possible. Racial discrimination did the opposite. It excluded large numbers of people from skilled employment, training and wealth. It left skills and purchasing power in the hands of a minority. Although there were temporary benefits for white people, keeping black people in low-skill, low-wage jobs eventually squeezed and distorted the consumer markets of southern Africa. The result was economic crisis and political instability that undermined governments and employers alike.

Unfair discrimination targeted at people with HIV has a similar effect. The effect of dismissing or refusing to employ a person just because he or she has HIV is to deny that person the opportunity to earn a living and to spend their earnings on themselves and their families. This leads to the loss of dignity as well as a range of other universally accepted rights and opportunities including education, health and eventually life.

Unfair discrimination entrenches the cycle of poverty. For example, refusing to employ people with HIV or AIDS:

- ❑ increases the number of people who are unemployed and therefore dependent on those with jobs (already very high);
- ❑ decreases the number of economically productive people;
- ❑ wastes public resources that have been invested in the education and training of people before they were infected.

Unfair discrimination will slow down the economic development of the region by increasing the dependency of people with HIV/AIDS and their families on the already limited resources of their governments. One of the resolutions taken at the Conference on AIDS and Employment noted that unfair discrimination by private employers does not make the costs of AIDS disappear:

“If not borne by the private sector (employer, insurance, industry etc.) they are shifted to the state or the household where the capacity to bear costs is lower and potentials for pooling the costs of risk between income groups less.”⁴¹

These are the most important reasons why the drafters of the Code set it within a framework of fundamental human rights. The Code does not create new rights. It merely translates rights that SADC countries have already endorsed into the employment context.⁴² This is in keeping with the approach that had been developed in other countries, for example the *Ten Principles for the Workplace* that have been drafted by the National Leadership Coalition on AIDS in the United States.⁴³

Patient rights

- ❑ The Code is based upon “patient rights, medical and occupational health principles ... and a human and compassionate attitude to individuals.”

Unfair discrimination adds to the stigma around AIDS and in turn makes it more difficult to control the HIV epidemic. This contributes to larger numbers of people being infected with HIV, becoming ill and dying.

⁴¹ Conference on AIDS and Employment in Southern Africa, 1994.

⁴² The African Charter on Human and People's Rights has been ratified by all SADC countries and the International Covenant on Civil and Political Rights has been ratified by all countries except Botswana and Swaziland.

⁴³ The National Leadership Coalition on AIDS is a private sector organization that was formed in 1987 in the United States to support business, labour and NGO initiatives in response to the AIDS epidemic. See NLCA, *Small Business and AIDS, How AIDS Can Affect your Business*.

In the introduction to the *International Guidelines on HIV/AIDS and Human Rights*, Peter Piot⁴⁴ and Mary Robinson⁴⁵ write that:

“There is increasing recognition that public health often provides an added and compelling justification for safeguarding human rights, despite the respect, protection and fulfillment which they merit in their own right. In the context of HIV/AIDS, an environment in which human rights are respected ensures that vulnerability to HIV/AIDS is reduced, those infected with and affected by HIV/AIDS live a life of dignity without discrimination and the personal and societal impact of HIV infection is alleviated.”⁴⁶

In keeping with this, the *International Guidelines* propose that the human rights that should be protected at work include “confidentiality, informed consent to testing, the duty to treat and the duty to ensure safe workplaces.”⁴⁷ These rights are all protected in the SADC Code.

Confidentiality: This ethical and human rights principle recognizes that all people have rights to privacy about personal medical conditions. It applies fully to HIV infection and AIDS. In an employment setting it means that a person infected with HIV should have full control over decisions about *who*, *how* and even *if* his or her colleagues are informed. Confidentiality must not be confused with secrecy. In a ‘safe’ workplace, where co-employees are educated about HIV and where unfair discrimination is prohibited people living with HIV are likely to want to be open about their infection.

Informed consent: This is an ethical principle deeply embedded in the medical profession. It means that when a patient is advised to undergo a medical operation he or she should fully understand the real and possible consequences of that operation. Applied to HIV testing it means that all people have a right to be fully informed about HIV and AIDS and to absorb how an HIV-positive result will affect their lives *before* agreeing to an HIV test. This can only be achieved through counselling.

The duty to ensure safe workplaces: HIV cannot be transmitted through casual contact between people at work. Therefore it is not justifiable to isolate individuals with HIV from other employees. In workplaces where employees come into contact with blood or other bodily fluids, or where there are sometimes accidents that can lead to blood spills, universal precautions must be introduced and always practised. Employees should be taught to regard all blood as possibly HIV-infected.

Business Efficiency

- The Code is based on “sound epidemiological data and prudent business practice”.

Presently, conducting business in southern Africa means operating in an environment where HIV prevalence in the workforce and in the consumer market is approximately 20%. This fact should influence business practice as much as other factors that distinguish industrialized countries from the developing world such as cultural and technological differences.

⁴⁴ Peter Piot became the Executive Director of UNAIDS in 1996.

⁴⁵ Mary Robinson took up the position of UN High Commissioner for Human Rights in 1997.

⁴⁶ Foreword, *International Guidelines on HIV/AIDS and human rights*.

⁴⁷ Ibid, Guideline 10, p. 26.

Unfortunately, emerging markets across the world are characterized by a rising incidence of HIV. Today the AIDS epidemic is spreading equally fast in Asia and parts of Latin America.⁴⁸ Therefore businesses do not have the option of re-locating to other parts of the developing world to avoid HIV/AIDS.

Epidemiological principles inform us that in an area with a high or rapidly rising incidence of HIV infection it is not possible for a business (or any institution) to isolate itself from the AIDS epidemic. Unfair measures that seek to “protect” a company from AIDS do not work. Indeed, without exception, the experience of employers has been that measures that take away the rights of employees make the AIDS epidemic more expensive for the workplace for a number of reasons:

- ❑ They add direct costs. Identifying people at work – or applying for work – who have HIV requires compulsory testing, replacing skilled and unskilled labour and complex recruitment strategies. Refusing to employ qualified and competent people because they have HIV may mean employing less suitable alternative candidates.
- ❑ They add indirect costs. These accrue from suspicion between employers and employees, and a demoralized, demotivated workforce.
- ❑ They may increase the prevalence of HIV. In the medium to long term they add to the burden of HIV/AIDS experienced by individual workplaces. For example, mandatory HIV testing of people joining the military has not lowered the prevalence rate among soldiers.⁴⁹ Compulsory testing does not lower the prevalence or incidence of HIV. The idea that testing is a way to stop HIV at the door of the factory or office is wrong. It undermines the real prevention messages of workplace education programmes.
- ❑ They prevent ‘shared responsibility’. A unilateral response from employers paralyzes the development of a common approach to AIDS by employers and employees. The Code is based on principles that recognize this. By combining strategies that are good for business, instil trust in employees and assist HIV prevention it aims to be as inclusive as possible.

The cost of unfair discrimination:

Unfair discrimination makes people afraid to show interest in HIV prevention and therefore undermines workplace-based health education and HIV prevention. Workers who have HIV, or who are worried that they may be infected, are forced to hide their infection and their fears – to protect their jobs. Unfair discrimination may reinforce people's ideas that AIDS is a punishment for ‘immoral’ behaviour and direct attention away from a realistic understanding of how HIV is transmitted.

⁴⁸ UNAIDS *Global Update*, December 1998.

⁴⁹ Despite the policy of mandatory screening, high HIV prevalence is reported in all of the defence forces of Africa. See: *Military HIV/AIDS Policy in Eastern and Southern Africa, A Seven Country Comparison*, Civil-Military Alliance to Combat HIV and AIDS, 1996.

3.2 Policy components of the Code

Based on the three principles explained earlier in this chapter the Code makes a series of specific recommendations about how to manage HIV/AIDS at work.

It is important to note that the Code is not advocating 'special rights' for employees with HIV. In fact it makes two important assertions:

1. "Employees with HIV should be treated the same as any other employee."
2. "Employees with HIV related illness, including AIDS, should be treated the same as any other employee with a life-threatening illness."

However, it explains that because of the "gravity and impact" of this unique illness special policies and measures are necessary. This is not a contradiction. Never before in modern history has an incurable virus affected so many people. Further, while there are many other illnesses in the developing world that cause illness and death none of them have gathered the same volume of stigma as AIDS. They do not primarily affect adults.

Education, awareness and prevention programmes

Key policy: The workplace is an excellent place to raise awareness among employers, employees and their families about how to prevent infection and live with HIV. Education, organized during working hours, is an investment that will benefit every workplace. If the promotion of health-seeking behaviour concerning HIV is combined with other health issues (smoking, alcohol consumption, workplace safety, managing stress) it will result in increased productivity and morale.⁵⁰ It is likely to instil trust and is the only way to reduce the long-term impact of HIV in the workplace.

Job access and job status

Key policy: HIV, or the suspicion that a person may have HIV, should not be considered when employing, training or promoting an employee. Identifying employees with HIV does not immunize a workplace from the impact of AIDS.

Workplace testing and confidentiality

Key policy: Like any other health condition, infection with HIV is a private (confidential) matter. Employees or employers should not be forced to disclose their HIV infection to managers, medical officers or human resource personnel. Disclosure is a matter of individual choice. Breaches of confidentiality will cause demoralization and disruption.

"Privacy and confidentiality about HIV/AIDS will continue to be a key issue, which needs sensitive handling from all concerned. But what needs to be dealt with is a radical shift in norms and values, to a culture in which the question of *how people get AIDS* - the moral, ethical and cultural issues, must be superseded by the issues of *how to support them*, assist them to lead meaningful lives in the community, and *how to prevent further spread* of the disease."⁵¹

⁵⁰Health-seeking behaviour includes instruction on how to practise safe sex, advocacy for having only one sexual partner, the recognition and early treatment of sexually transmitted diseases (STDs) and voluntary HIV testing.

⁵¹ Williams R, *Evaluation of the Carletonville STD/HIV intervention Project*, 1999.

Individual HIV testing is not relevant to the day-to-day management of the workplace. However, education should explain the advantages of HIV testing if it is on a voluntary and confidential basis and is coupled with pre and post test counselling.⁵²

Managing illness and job security

Key policy: Employees with HIV-related illnesses should be treated according to the rules that already govern sickness under company policy and in accordance with existing labour laws. Where it is possible, “reasonable accommodation” should be made for employees whose illness makes them unable to do jobs that become too stressful or strenuous, although this will depend on the size of the workplace concerned. It is justifiable to terminate employment as a result of incapacity, but it should be done fairly and without discrimination.

Occupational benefits

Key policy: Greater illness and death will make it necessary to review and restructure many employee benefits (such as death and disability benefits, pensions and provident funds). This should be done openly and through negotiation. Benefits should not be restructured before there has been research to show the actual impact that AIDS will have on the viability of a benefit. Once this has been done benefits should not be restructured in a way that unfairly excludes employees with HIV, or drastically limits medical cover for HIV and AIDS.⁵³

Risk management, first aid and compensation

Key policy: In the vast majority of workplaces there is not a risk of occupational infection. In working environments where there is a small risk (because employees come into contact with blood or other body fluids) the risk of accidental HIV infection can be eliminated by simple and cheap procedures. For example, teaching employees about infection control procedures (“universal precautions”) and establishing and maintaining a properly stocked first aid box.

Protection against victimization and grievance handling

Key policy: Fear of people with HIV – either among clients or co-workers – is caused by ignorance. Education leads to AIDS awareness, which takes away fear and creates better relations at work. Disciplinary action is justified against employees who create fear and hatred against co-workers with HIV, just as it is on the grounds of sexual harassment or racial discrimination.

Information, monitoring and review

Key policy: HIV/AIDS is an evolving epidemic. Its impact on the economy of the region as well as on the individual workplace is still being studied. All social partners should work together to collect and share information. Policies, including the SADC Code, should be reviewed in the light of new information. Until this happens the success of the Code will depend on an ongoing campaign of advocacy, education and lobbying to persuade governments and employers at national level to integrate it into their national law and make it legally binding.

Some of the arguments in favour of the implementation of the Code are addressed in the next chapter.

⁵² Anonymous and voluntary surveillance studies of HIV prevalence amongst a particular workforce are sometimes useful to predict the impact HIV may have on employee benefits or staff turnover. But such studies can also cause confusion and conflict and therefore need to be carefully researched. They should not delay the implementation of workplace prevention programmes.

⁵³ Most small employers in Africa do not have employee benefits. Where there are benefits such as medical aid schemes the current thinking is that it is more cost-effective to offer reasonable health care and treatment for HIV than to exclude it entirely.

4 BUILDING PARTNERSHIPS TO PROMOTE THE CODE

This chapter looks at the part that was played by different organizations in southern Africa to promote the SADC Employment Code and the partnerships that emerged during its development. It focuses mainly on the experience of three SADC countries – Botswana, South Africa and Zimbabwe.

4.1 Botswana: The National Taskforce on HIV/AIDS at the Workplace

In Botswana the process of developing a Code on AIDS and Employment led to a much wider cooperation between business organizations and the trade unions on issues of AIDS in the workplace than had existed before.

Early in 1995 the Botswana Federation of Trade Unions (BFTU) drafted an Employment Code with the assistance of the Organisation of African Trade Union Unity (OATUU). In November that year the BFTU hosted a tripartite workshop on economic and employment issues and HIV. This meeting was attended by several government representatives, trade unions and the Botswana Business Coalition on AIDS (BBCA). The meeting aimed to gather consensus on the need for an employment Code. It also led to a decision to establish a National Taskforce on HIV/AIDS at the Workplace.

Since 1996 the National Taskforce has carried out research and has supported a number of workplace programmes that have begun to prepare employers and employees to deal with the many challenges of HIV and AIDS. Among the Task Force's achievements so far are:

- ❑ An ill-health monitoring guideline which companies can use to carry out in-house impact assessments;
- ❑ A workplace action plan on HIV/AIDS, documenting resources and support for each activity;
- ❑ The setting up of bipartite health and social welfare committees in several companies.⁵⁴

4.2 Zimbabwe: The Intersectoral Committee on AIDS and Employment

At the end of 1994 the National AIDS Control Programme (NACP) in Zimbabwe called together employers, trade unions and NGOs involved in workplace prevention programmes. This group included the Employers Council of Zimbabwe (EMCOZ), the Confederation of

⁵⁴ The Botswana Task Force on HIV and AIDS has prepared six reports detailing this intervention. (1) *Impact of HIV/AIDS and Options for Intervention: Results of a Five Company Pilot Study*, August 1997 (2) *Guidelines on How to carry out a Workplace HIV/AIDS impact assessment* (3) *Impacts of and Interventions for AIDS at the Workplace – Workshop Report*, August 1997 (4) *Report of Training days for Health and Social Welfare Committees at the Workplace*, June 1998 (5) *Health Survey*, 1998, (6) *Progress Report of Task Force Activities*, November 1998.

Zimbabwe Industries (CZI), government bodies, the Zimbabwe Congress of Trade Unions (ZCTU) and two nongovernmental organizations, SAfAIDS and the Matabeleland AIDS Council.

The group, which was initially called the 'Tripartite Plus', went through a number of brainstorming sessions on HIV/AIDS and employment. It was chaired by the NACP, but this role was later handed over to the Department of Labour. This approach resolved the issue of interministerial collaboration which, in many countries, Zimbabwe included, is a persistent problem.

The committee launched a policy formulation process:

- ❑ A consultation phase was planned to identify the issues, points of attention and resource persons.
- ❑ Consultative meetings were held in the two main industrial centres, Harare and Bulawayo.

These meetings allowed for an important categorization of issues into the following groups:

- ❑ those that could be made legally binding (if approved by the existing Tripartite) as Labour Regulations that would be gazetted as attachments to the existing Labour Relations Act;
- ❑ issues that were more of a policy nature, such as social security and occupational benefits, medical aid and general production and productivity issues.

The drafting phase involved holding a series of intensive meetings between the partners. This allowed for strong debate. It showed considerably more consensus than was expected beforehand around key issues such as testing, occupational benefits and medical aid. The outcome was a draft set of policy recommendations. Thereafter a second round of consultative meetings in Harare and Bulawayo was organized to receive feedback on this draft. This generated further debate and allowed for amendments to the draft codes. This next draft was circulated widely and in large numbers within the country as the *Draft Employment Code on HIV/AIDS - Volume 1 (Industrial Relations)* and *Volume 2 (Social Security and Production Strategies)*.

Individual members of the Intersectoral Committee then made formal and informal presentations to employer and employee bodies. These and other comments and submissions were used to finalize the draft code. This code was presented to the Labour Tripartite and approved after discussion and some changes. Thereafter, codification of the text in the appropriate language was undertaken through external expertise and submitted to the Attorney General's office.

In Zimbabwe several important lessons were learnt:

- ❑ A small motivated expert group of persons skilled in policy formulation and process thinking are required to take up the issue and to identify the possibilities for an open, consultative process. The informal networks of the members are essential for generating participation in the debate. This includes having contacts with donor agencies to ensure access to appropriate funding.
- ❑ Taking the time for planning, consultation and discussion ensured broad acceptance of the idea and allowed a wide range of views to be heard and incorporated. The distribution of the draft code is an essential part of this process.

- ❑ Formulation of an Employment Code requires patience, as it takes time for organizations to become involved. But in the long term it is more likely to pay off rather than taking short cuts for quick limited results.
- ❑ Membership of the intersectoral committee: this expert group should include people with HIV/AIDS and representatives of NGOs that have gained experience in running workplace programmes and are involved in information dissemination.
- ❑ Ideally, the government departments responsible for labour regulations and/or occupational health should be prepared to take a lead role.
- ❑ Enlisting broad participation of the parties concerned and affected by a proposed HIV/AIDS and Employment Code is a key to ensuring the necessary debate and attention for the formulation process. It is also essential for the achievement of consensus around critical issues.
- ❑ Where possible, the drafting of a code should be linked to the existing structures such as the Labour Tripartite and Employment councils, as well as other existing umbrella bodies concerned, such as those for insurance and medical aid. Particular care should be taken to ensure the input of people living with HIV, human and patient rights bodies and the churches.⁵⁵

4.3 South Africa: The contribution of nongovernmental organizations (NGOs)

In June 1993 the AIDS Consortium, a network of NGOs, AIDS service organizations (ASOs) and individuals based in Johannesburg organized a conference on AIDS, human rights and employment.⁵⁶ This Conference proposed that a 'Code of Conduct on AIDS and Employment' should be drafted and submitted to the government. It recommended that its principles be made legally binding on employers and employees. A committee that included human rights activists, business people and trade unionists was set up and completed the first draft in August 1994.

In 1995 the AIDS Consortium launched a lobbying campaign to make the Code known. This campaign, which included seminars and workshops, targeted:

- ❑ Government: Meetings were held with senior government officials and politicians.
- ❑ ASOs and NGOs: The Code was made widely available and through NGOs and ASOs copies found their way to hundreds of South African towns and cities.
- ❑ Trade unions: At the end of 1995 a young worker who had been dismissed from his factory because he had HIV addressed a conference of 500 delegates of the Congress of South African Trade Unions (COSATU) which has a membership of 1.5 million people. The Code was adopted by COSATU as its policy. The support of South Africa's biggest trade union federation added legitimacy to the

⁵⁵ Russell Kerkhoven, Deputy Director, SAfAIDS (formerly attached to the NACP through WHO/GPA in Zimbabwe).

⁵⁶ AIDS Consortium, 2nd Conference on AIDS and Human Rights, 1993.

Code. Thereafter many trade union members began to use the Code to approach local workplaces with recommendations for workplace AIDS policies and prevention programmes.

As a result of this campaign the Code became a de facto guide for trade unionists and managers on acceptable policies and responses. Several major companies and trade unions simply adopted the Code as policy. In Gauteng, South Africa's most economically developed Province, the Code became the official policy of the Provincial Government.

This process helped to establish a wide sense of involvement with the Code.

In 1995, 5000 copies were distributed nationwide and the Code was printed as a full-page advertisement in a national business newspaper. After the public was invited to make submissions over 50 written responses were received. The majority of these were positive:

"On behalf of the national Executive Committee of the National Association of People Living with HIV/AIDS (NAPWA) we would like to congratulate you for a highly beneficial guideline to the business sector of South Africa."

"I have forwarded copies of the draft to Israel's National Union of Labour (Histadrut), to the Israel Civil Liberties Union, and to the medical officer of my employer, El Al Airlines."

"Please accept my congratulations in this first class attempt to educate public opinion and especially employers." - Professor Kader Asmal, Minister of Water Affairs and Forestry.

But, in addition, criticisms were also received from some companies, the Department of Correctional Services (prisons), a mining house, a health care business, banks and some members of the Medical Association of South Africa (MASA). The general criticism tended to be that it was "too employee orientated", "too prescriptive" or that it "placed the rights of the infected before the rights of the uninfected." For example, one employer commented that:

"medical testing by employers was justifiable because of the employers' vicarious liability to the public in regard to an employee's ability to discharge his duties adequately and safely." However, this respondent also accepted that "medical examinations should not be arbitrarily imposed in a discriminatory fashion in relation to HIV."

On the subject of employee benefits a fund manager argued in support of pre-benefit testing of new employees and the exclusion of those with HIV on the grounds that:

"nondiscrimination would lead to 25% of employees (those with HIV) severely prejudicing 75% who are HIV negative."

One of the major banks in South Africa opposed the proposal that the Code should be made law because:

"most employers will not be in a financial position to fulfil all the obligations embodied in the Code with the definite possibility of being found guilty of an unfair labour practice."

Where it was considered reasonable and in keeping with the principles and objectives of the Code, public comment was incorporated into a second draft that was produced in October 1995. Thereafter 10 000 more copies were printed and the Code was formally presented to the Government with the recommendation that it become a Regulation attached to South Africa's new Labour Relations Act (LRA).

Since 1996, the Code has continued to be used by employers and trade unions as a guideline to assist with the formulation of employment policy. Several of its recommendations have been incorporated into new employment laws, such as the Employment Equity Act and Medical Schemes Act (see Chapter 5). It is also serving as a resource document for the drafting of a Code of Good Practice on Employment.

4.4 Comparative analysis of the process in Botswana, South Africa and Zimbabwe

It is important to note the differences in the approach taken in these three countries:

- ❑ In Zimbabwe the Government played an important role initiating the process but the trade unions gave it an ongoing momentum.
- ❑ In Botswana the first draft of a Code was a trade union initiative but a national business organization used the Code as an opportunity to improve its HIV prevention programmes.
- ❑ In South Africa, NGOs took the lead in publicizing and promoting the Code, but at all times they attempted to gain the support of government departments, trade unions and employer organizations.

Each response involved the combination of stakeholders who are needed for effective workplace HIV prevention. Each stakeholder brought different strengths to the discussions. The challenge for the implementers of the Code will be to continue to combine these strengths.

The different approaches all led to the same end. Lobbying, research and negotiations around National Codes of Conduct contributed to the development of the SADC Code. By the time the regional Code was endorsed by the SADC Council in September 1997 the three campaigns referred to above had guaranteed that the principles and purposes of such a Code were already well known by several governments, trade unions and the business community. In addition employment practice was influenced. The Code helped to make employees and trade unionists more aware of their rights. A broad consensus was achieved on the principle that a policy framework for the response to issues of AIDS and the workplace must always take account of the rights and needs of people with HIV or AIDS.

The importance of involving trade unions

There are many advantages to trade union involvement in campaigns on HIV/AIDS.

Trade unions often have:

- ❑ Strong internal networks that can be used to carry information and messages about AIDS;

- ❑ A reservoir of potential peer educators amongst shop-stewards and other office-bearers;
- ❑ An interest in the health and safety of their members that makes them effective advocates of health promotion and disease prevention;
- ❑ Existing channels for discussion with employers and governments.

In southern Africa the importance of the involvement of trade unions is being proved in practice. A great deal of the initiative for the development of the SADC Code came from the Organisation of African Trade Union Unity's (OATUU) Health, Safety and Environment Programme. OATUU, which is based in Harare in Zimbabwe, worked closely with trade unions, businesses and NGOs and organized a series of workshops on AIDS and Employment.

Table 4 indicates some of the countries and partnerships that organized tripartite workshops on AIDS and Employment, as well as the outcomes of these workshops.

Table 4. Tripartite workshops on AIDS and employment

Country	Partnership	Outcomes
Botswana	OATUU with the Botswana Federation of Trade Unions, the Botswana Business Coalition on AIDS, the Ministry of Labour and Home Affairs and the Ministry of Health.	Decision to form the Botswana Task Force on AIDS in the Workplace. Agreement to take forward the Botswana Code on AIDS and Employment for national legislation. Decision to conduct research to assist company activities on HIV/AIDS. ⁵⁷
Lesotho	OATUU with the Lesotho Trade Union Congress.	The workshop divided into several working groups on HIV/AIDS that drafted proposals. These included recommendations that there should be collective bargaining agreements in all companies with compulsory education on HIV/AIDS and that trade unions needed to review the Labour Code to include protection against discrimination due to HIV/AIDS. ⁵⁸

⁵⁷ Workshop Report, Tripartite Workshop on Economic Policy, Employment and HIV/AIDS, Botswana, November 1996.

⁵⁸ Report of the Lesotho Trade Union Congress / OATUU HSEP Workshop on Trade Union Action and AIDS, Lesotho, May 1995.

Country	Partnership	Outcomes
Malawi	OATUU with the Malawi Congress of Trade Unions, the Ministry of Labour and Manpower Development, the Employers Consultative Association of Malawi, and the National AIDS Control Programme.	It was agreed that the Workplace Task Force should be expanded to include the Malawi Congress of Trade Unions. A draft of a Code of Practice on AIDS and Employment was discussed. It was agreed that this Code should be widely circulated and comments obtained. After further review by the National AIDS Committee and the national tripartite it should be finalized and legislated ⁵⁹ for application in the workplace.

Similar workshops have taken place in Mozambique, Namibia, South Africa, Zambia and Zimbabwe.

One advantage of this series of workshops has been that there are many similarities between the codes that have been developed at national level and the southern African Code. It also allowed experiences to be shared across countries.

The importance of involving the private sector

In South Africa the AIDS Law Project, an NGO, raised funds to publish the draft Employment Code in a national business newspaper. This brought it to the attention of business leaders. Several business organizations arranged 'in-house' discussions on the Code, and initially the response was not supportive. The opposition appeared to have been motivated by a desire to defend management's autonomy, particularly around matters that involve hiring and firing. The main issues that caused disagreement were the proposals to prohibit pre-employment HIV testing and the suggestion that there should be nondiscriminatory access to employee benefits. As a result, some groups drafted their own versions of an employment code/guideline.⁶⁰ This reaction required even greater lobbying on the part of NGOs and prompted research and the development of arguments (outlined in Chapter 2) to try and persuade business organizations that human rights and economic concerns can be accommodated.

Two principles should be emphasized here:

1. It is important to identify areas of agreement rather than disagreement. Often the gap between business and the community is a small one, but it gets exaggerated and eventually delays action on areas of agreement. This can prevent the introduction of effective HIV prevention in the workplace, creating unnecessary conflicts that make collaboration with other social partners to limit the impact of HIV and AIDS more difficult.
2. Some of the issues are complex and cannot be resolved by advocacy alone. For example the question of the restructuring of employee benefits cannot be resolved without proper research into the impact of AIDS on the workplace. Such issues need to be identified as early as possible so that plans for collaborative research can be set in motion.

⁵⁹ Workshop Report, Tripartite Workshop on Economic Policy, Employment and HIV/AIDS, Malawi, November 1996.

⁶⁰ Business South Africa (BSA) and the South African Chamber of Business (SACOB) both drafted their own Employment Guidelines, which were advertised and made available to their members.

5 THE CHALLENGES OF IMPLEMENTATION

The process of developing a Code on HIV/AIDS and Employment for Southern Africa was an instructive one. It was full of challenges and lessons for all the people and organizations involved. The outcome is a policy framework that has the support of the highest levels of government. But the greatest challenge lies ahead – that is with the implementation and effective use of the Code by SADC member states, trade unions, employers and governments.

The drafting of national Codes by several SADC member states laid the foundation for a Regional Code. Now, the approval of the Regional Code by the SADC Council should be used:

- to proceed with the formal implementation of Employment Codes in countries where a 'draft' Code already exists, or has been legislated; and
- to start a process, similar to that undertaken by South Africa, Zimbabwe and Botswana, in countries where, so far, there have been no initiatives around AIDS and employment.

At a meeting of Ministers and Social Partners of the Employment and Labour Sector that was held in Swaziland in April 1999 reports were provided on the current status of the Code among SADC members. These are summarized in Table 5.

Table 5. Status of Code⁶¹

COUNTRY	NATIONAL CODE/ POLICY FORMULATED	IMPLEMENTING ASPECTS OF THE REGIONAL CODE
Angola	+ Although no report was submitted Angola is finalizing a national policy / Code on AIDS in the Workplace	+
Botswana	Y	Y An Employment Code has been approved by the National AIDS Advisory Board and submitted to the Office of the Attorney General before going to Parliament.

⁶¹Based on reports provided at a Meeting of Ministers and Social Partners of the Employment and Labour Sector, Swaziland, April 1999. Thanks are due to Ms Cecilia Mulindeti, Senior Economist with the SADC Employment and Labour Sector for providing this report.

COUNTRY	NATIONAL CODE/ POLICY FORMULATED	IMPLEMENTING ASPECTS OF THE REGIONAL CODE
Democratic Republic of the Congo	+	+
Lesotho	N	Y
Malawi	Y	Y
Mauritius	Y	Y
Mozambique	N Although no report was submitted Mozambique is finalizing a national policy / Code on AIDS in the Workplace.	N
Namibia	Y	Y Guidelines on the Implementation of a National Code were passed by Parliament in 1998.
Seychelles	+	+
South Africa	Y	Y The national Ministries of Labour and Health are finalizing the draft of an Employment Code. It is expected that the Code will become a part of the Employment Equity Act.
Swaziland	Y	+
United Republic of Tanzania	+	Y
	Although no report was submitted the United Republic of Tanzania is finalizing a national policy/ Code on AIDS in the Workplace.	
Zambia	+	Y
Zimbabwe	Y	Y A Statutory Instrument containing Regulations for the management of HIV/ AIDS in the workplace was passed in 1998.

Key:

- Y = National Code / policy formulated or implementing regional Code
 N = No Code or policy formulated
 + = No report submitted

In countries that are at war there are enormous obstacles to HIV prevention. However, unlike a decade ago, most of the region is now at peace. AIDS has become the greatest threat to development, life and household security. At the SADC Employment and Labour sector meeting in April 1999 "Ministers and Social Partners urged Member States that had not formulated national policies and programmes on HIV/AIDS and Employment and those that were not implementing the Regional Code to do so."⁶² However, trade unions, employers and NGOs should not wait for the Code's formal incorporation into legislation by their governments. There is a great deal that can be done now.

Below are some examples and suggestions of actions and activities that can be undertaken immediately.

5.1 Activities that could be undertaken by trade unions and employers

In South Africa less than 25% of workplaces had implemented HIV or AIDS prevention programmes by 1999.⁶³ This is also true in Botswana, Namibia and Zimbabwe. The SADC Code can be used by trade unionists and employers as a policy guideline for the introduction of HIV/AIDS prevention programmes.

Popularize the Code!

The Zimbabwean Labour Relations (HIV/AIDS) Regulations state that every employer should provide education about HIV/AIDS during working hours. But in order to ensure that this takes place trade unions and employers will need to popularize the Code among their members. They will also need to carry out a survey of NGOs and other organizations that can be recruited to make sure that this proposal is carried out.

Discussions can be organized around the Code within and between trade union federations and employer organizations. Thereafter it could:

- ❑ Be presented for negotiations and adoption *at industry level*. For example in South Africa the Southern African Clothing and Textile Workers Union (SACTW) has used the Code to develop a policy for its industry. This policy is being presented to the National Bargaining Council and after it is accepted will become a legal standard for all employers and employees in the industry.
- ❑ Form the basis for a contract on shared responsibilities for HIV/AIDS prevention *at factory level*. For example, trade union members at a local engineering factory could use the Code to start negotiations with their managers over an AIDS prevention programme.
- ❑ Be used as a training tool for workers and managers on the shop floor on how to deal with issues of HIV/AIDS in the workplace.

⁶² Resolution of the Meeting of Ministers and Social Partners of the Employment and Labour Sector, April 1999.

⁶³ In 1998 the AIDS Legal Network in South Africa commissioned research into business attitudes to HIV/AIDS. See: H McLean et al, *Attitudes to HIV-Testing And Legal Reform in the South African Public and Private Sectors*, August 1998.

5.2 Activities that could be undertaken by nongovernmental organizations

Nongovernmental organizations employ hundreds of thousands of people in southern Africa. They can set an example by adopting the Code as their own employment policy.

They can also play an important role by using the Code to make their own partners more aware of all the dimensions of the AIDS epidemic. For example, the Code can be used by organizations involved in development work, women's empowerment and children's rights.

The South African National NGO Coalition has over 1000 member organizations. At its annual conference in 1998 it adopted the SADC Code as its employment policy and resolved to lobby the government to make the Code legally binding on all employers.

5.3 Activities that could be undertaken by government departments and members of parliament

The decision of the SADC Heads of Government to unanimously adopt the Code gives it great political power. The Code's political authority can be used by government departments and National AIDS Control Programmes (NACPs) to begin to introduce measures that are needed for effective workplace programmes. For example:

- ❑ The Code's recommendation that condom promotion should be a component of workplace programmes can be used by NACPs to approach employers and trade unions to find ways for effective condom distribution in the workplace.
- ❑ The Code's proposals on nondiscrimination and safety at work can be used by ministries of labour and members of parliament to bring about changes in the law that would prevent unfair discrimination and improve AIDS education and prevention in the workplace. For example, the South African Parliament has incorporated various parts of the SADC Code into new legislation. The Employment Equity Act, which was passed in 1998, lists 'HIV status' side by side with other constitutional grounds where discrimination is considered to be automatically unfair. It also contains a clause that prohibits pre-employment HIV testing and states that: "Testing of an employee to determine that employee's HIV status is prohibited unless such testing is determined to be justifiable by the Labour Court in terms of Section 50 (4) of this Act."⁶⁴ In addition, the Medical Schemes Act of 1998 makes it unlawful for a medical insurance company to arbitrarily refuse a person membership of the scheme because of their state of health.⁶⁵ Moreover, a new labour regulation has been approved by parliament that will make it mandatory for every workplace to have 'universal precautions' available in case of workplace accidents.⁶⁶

⁶⁴ Employment Equity Act, 55 of 1998.

⁶⁵ Medical Schemes Amendment Act, of 1998.

⁶⁶ This recommendation was made by the South African Law Commission Project Committee on HIV/AIDS, First Interim Report, 1996. It was supported by parliament.

5.4 Activities that could be undertaken by partnerships

The Intersectoral Committee in Zimbabwe and the National Taskforce on HIV/AIDS in the Workplace in Botswana are examples of partnerships that should be emulated by every SADC country. Partnerships on AIDS in the Workplace should be formed to:

- ❑ initiate joint research into issues such as the impact of HIV and AIDS on employee benefits and to draft recommendations on how this impact can be managed
- ❑ carry out surveys that will establish the actual levels of awareness about HIV among employers and employees
- ❑ implement and monitor pilot interventions and publicize examples of effective programmes.

5.5 No more time to lose!

As in other developing countries, especially in Asia, many of the challenges to society that AIDS creates are only just beginning to be confronted. Southern Africa has passed the 'hidden' or 'invisible' stage of the AIDS epidemic. Millions of people have HIV and there are hundreds of thousands of people with AIDS. The impact of AIDS on workplaces and homes is now obvious and yet stigma and fear mean that the majority of company responses are still characterized by silence. We must break the silence. The message that must be conveyed to employers and employees across the region is that it costs more to do nothing!

Africa's leaders are talking of an "African Renaissance" in the next century. This Renaissance will depend on people to work, to create the nation's wealth and wealth for their own families and friends. It will also depend on politicians who recognize, enforce and take steps to realize the rights of all people to work, including people with HIV, AIDS or other disabilities. Implementing the SADC Code on HIV/AIDS and Employment will be central to the success of this dream.

6 Appendices

Appendix A: The Code on HIV/AIDS and Employment in the Southern African Development Community (SADC)

GENERAL STATEMENT

Human Immuno-deficiency Virus (HIV) infection and the Acquired Immune Deficiency Syndrome (AIDS) in the countries of the Southern African Development Community (SADC) (and globally) is a major health problem with employment, economic and human rights implications. As one response to this problem the SADC Employment and Labour Sector has established this code on the industrial relations standards on HIV/AIDS, the “Code on AIDS and Employment”. (Termed after this ‘the code’). It should be noted that the provisions of this code applies only to workplaces and cannot and should not be construed as applying to other areas of law such as national immigration laws, policies and related administrative procedures.

POLICY PRINCIPLES

The same ethical principles that govern all health/medical conditions in the employment context apply equally to HIV/AIDS. However, the gravity and impact of the HIV/AIDS epidemic and the potential for discrimination create the need for a specific code on HIV/AIDS and employment. At the same time, given the increased risk of spread of the disease under conditions of economic insecurity, nondiscriminatory approaches enable economic and public health management. The code will aim to ensure nondiscrimination between individuals with HIV infection and those without and between HIV/AIDS and other comparable health-medical conditions.

The regional nature and implications of the epidemic and the desire to harmonise national standards in dealing with HIV/AIDS motivate this regional code. This code aims to ensure that SADC member states develop tripartite national codes on AIDS and Employment that shall be reflected in law. It presents guiding principles for and components of these national codes.

The code on AIDS and Employment is based on the fundamental principles of human rights and patients’ rights, WHO/ILO and regional standards and guidelines, medical and occupational health ethical principles, sound epidemiological data, prudent business practice and a humane and compassionate attitude to individuals. The approach aims to achieve a balance in protecting the rights of all parties, including those with and without HIV, employers, employees, state and others. This will include obtaining a balance between rights and responsibilities, and between individual protection and cooperation between parties. Employees with HIV should be treated the same as any other employee. Employees with HIV related illness, including AIDS, should be treated the same as any other employee with a life-threatening illness.

In its scope, the code should:

- (a) cover all employees and prospective employees;
- (b) cover all workplaces and contracts of employment;
- (c) cover the specific policy components detailed below, viz: job access, workplace testing, confidentiality, job placement, job status, job security, occupational benefits, training, risk reduction, first aid, workers' compensation, education and awareness, prevention programmes, managing illness, protection against victimisation, grievance handling, information, monitoring and review.

SADC member states should ensure that interactions between them are consistent with the principles and policy components of this code and that they share and disseminate information to enable an effective and planned response to the epidemic.

Policy development and implementation is a dynamic process so that the code on AIDS and employment should be:

- (a) communicated to all concerned;
- (b) routinely reviewed in the light of epidemiological and scientific information;
- (c) monitored for its successful implementation and evaluated for its effectiveness.

POLICY COMPONENTS

1. **EDUCATION, AWARENESS AND PREVENTION PROGRAMMES**

- 1.1 Information, education and prevention programmes should be developed jointly by employers and employees and should be accessible to all at the workplace. Education on HIV/AIDS should where possible incorporate employee families.
- 1.2 Essential components of prevention programmes are information provision, education, prevention and management of STDs, condom promotion and distribution and counselling on high risk behaviour. Workplace AIDS programmes should cooperate with and have access to resources of National AIDS Programmes.

2. **JOB ACCESS**

There should be no direct or indirect pre-employment test for HIV. Employees should be given the normal medical tests of current fitness for work and these tests should not include testing for HIV. Indirect screening methods such as questions in verbal or written form inquiring about previous HIV tests and/or questions related to the assessment of risk behaviour should not be permitted.

3. **WORKPLACE TESTING AND CONFIDENTIALITY**

- 3.1 There should be no compulsory workplace testing for HIV. Voluntary testing for HIV on the request of the employee should be done by a suitably qualified person in a health facility with informed consent of the employee in accordance with normal medical ethical rules and with pre- and post-test counselling.

3.2 Persons with HIV or AIDS should have the legal right to confidentiality about their HIV status in any aspect of their employment. An employee is under no obligation to inform an employer of her/his HIV/AIDS status. Information regarding the HIV status of an employee should not be disclosed without the employee's written consent.

3.3 Confidentiality regarding all medical information of an employee or prospective employee should be maintained, unless disclosure is legally required. This applies also to health professionals under contract to the employer, pension fund trustees and any other personnel who obtain such information in ways permitted by the law, ethics, the code or from the employee concerned.

4. **JOB STATUS**

HIV status should not be a factor in job status, promotion or transfer. Any changes in job status should be based on existing criteria of equality of opportunity, merit and capacity to perform the work to a satisfactory standard.

5. **HIV TESTING AND TRAINING**

In general, there should be no compulsory HIV testing for training. HIV testing for training should be governed by the principle of nondiscrimination between individuals with HIV infection and those without and between HIV/AIDS and other comparable health/medical conditions.

6. **MANAGING ILLNESS AND JOB SECURITY**

6.1 No employee should be dismissed merely on the basis of HIV status, nor should HIV status influence retrenchment procedures.

6.2 Employees with HIV related illness should have access to medical treatment and should be entitled, without discrimination, to agreed existing sick leave provisions.

6.3 HIV infected employees should continue to work under normal conditions in their current employment for as long as they are medically fit to do so. When on medical grounds they cannot continue with normal employment, efforts should be made to offer them alternative employment without prejudice to their benefits. When the employee becomes too ill to perform their agreed functions the standard benefits and conditions and standard procedures for termination of service for comparable life-threatening conditions should apply without discrimination.

7. **OCCUPATIONAL BENEFITS**

7.1 Government, employers and employee representatives should ensure that occupational benefits are nondiscriminatory and sustainable and provide support to all employees including those with HIV infection. Such occupational benefit schemes should make efforts to protect the rights and benefits of the dependants of deceased and retired employees.

7.2 Information from benefit schemes on the medical status of an employee should be kept confidential and should not be used by the employer or any other party to affect any other aspect of the employment contract or relationship.

7.3 Medical schemes and health benefits linked to employment should be nondiscriminatory. Private and public health financing mechanisms should provide standard benefits to all employees regardless of their HIV status.

7.4 Counselling and advisory services should be made available to inform all employees on their rights and benefits from medical aid, life insurance, pension and social security funds. This should include information on intended changes to the structure, benefits and premiums to these funds.

8. RISK MANAGEMENT, FIRST AID AND COMPENSATION

- 8.1 Where there may be an occupational risk of acquiring or transmitting HIV infection, appropriate precautionary measures should be taken to reduce such risk, including clear and accurate information and training on the hazards and procedures for safe work.
- 8.2 Employees who contract HIV infection during the course of their employment should follow standard compensation procedures and receive standard compensation benefits.
- 8.3 Under conditions where people move for work, government and organisations should lift restrictions to enable them to move with their families and dependants.
- 8.4 People who are in an occupation that requires routine travel in the course of their duties should be provided with the means to minimise the risk of infection including information, condoms and adequate accommodation.

9. PROTECTION AGAINST VICTIMISATION

- 9.1 Persons affected by or believed to be affected by HIV or AIDS should be protected from stigmatisation and discrimination by co-workers, employers or clients. Information and education are essential to maintain the climate of mutual understanding necessary to ensure this protection.
- 9.2 Where employers and employees agree that there has been adequate information and education and provisions for safe work, then disciplinary procedures should apply to persons who refuse to work with an employee with HIV/AIDS.

10. GRIEVANCE HANDLING

Standard grievance handling procedures in organisations, in labour and civil law that apply to all workers should apply to HIV related grievances. Personnel dealing with HIV related grievances should protect the confidentiality of the employee's medical information.

11. INFORMATION

Government should collect, compile and analyse data on HIV/AIDS, sexually transmitted diseases and tuberculosis and make it available in the public domain. SADC member states should cooperate in making available national data for monitoring and planning an effective response to the regional health, human resource, economic and social impact of the AIDS epidemic.

12. MONITORING AND REVIEW

Responsibility for monitoring and review of the code and its implementation should lie with the parties to the tripartite at national and regional level and with the SADC Employment and Labour Sector.

Appendix B: The Namibian Code⁶⁷

No. 78 1998

GUIDELINES FOR IMPLEMENTATION OF NATIONAL CODE ON HIV/AIDS IN EMPLOYMENT

In terms of section 112 of the Labour Act, 1992 (Act No 6 of 1992) I hereby, in the Schedule to this notice, publish guidelines and instructions to be followed and adhered to by all employers and employees for the purpose of the application of the relevant provisions of the Act in respect of HIV/AIDS in employment.

JOHN M SHAETONHODI
Acting Minister of Labour
19 March 1998

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⁶⁷ This Code applies to all employers in Namibia. Although the Namibian Defence Force is excluded from the general provisions of the Namibian Labour Act, it is bound by the Act's sections on nondiscrimination. It is therefore believed that the Employment Code does apply to the NDF.

1. INTRODUCTION:

- 1.1 With the world-wide marked increase in number of persons infected with the human immunodeficiency virus (HIV) and suffering from acquired immuno-deficiency syndrome (AIDS) mainly in the economically active part of the population, the 20 to 50 years age group, the employers, employees and their organisations show a high level of anxiety in regard to the impact of the pandemic on the work environment.
- 1.2 From an initial response of denial, to a perception of AIDS as a medical problem, AIDS is progressively being recast as a development problem and an issue for all sectors.
- 1.3 Loss of employment and individual income, loss of employees without adequate availability of replacement, and a subsequent decline in production and national income can post a severe and detrimental effect on the social and economic stability and the growth of a country. This is so in view of the fact that HIV/AIDS will affect economic growth and production through the illness and death of productive people and through the diversion of resources from savings (and eventually investment) to care.

2. OPTIONS AND RESPONSES:

- 2.1 In response to the AIDS pandemic and its volatile and dynamic nature, the Ministry of Labour, in conjunction with the Ministry of Health and Social Services and with the wide tripartite consultation through the Labour Advisory Council, has formulated the National Code on HIV/AIDS and Employment for HIV prevention and AIDS management. This code is proposed as an integral part of the government's commitment to address most of the major issues related notably to the prevention of new infections, as well as to the provision of optimal care and support for the workforce.
- 2.2 Workplace based activities that locate HIV prevention and AIDS management in a sustained and comprehensive programme of health promotion have demonstrated gains in general health indicators.
- 2.3 This implies a need for stronger public health approaches in the productive sectors.

3. POLICY PRINCIPLES:

- 3.1 The same ethical principles that govern all health/medical conditions in the employment context should apply equally to HIV/AIDS.
- 3.2 The gravity and impact of the HIV/AIDS epidemic and the potential for discrimination created the need for this "National Code on HIV/AIDS and Employment" to be based on the fundamental principles of human rights embodied in the Constitution of the Republic of Namibia, the provisions of the Labour Act (Act No 6 of 1992), occupational health principles, sound epidemiological data, prudent business practice and a humane and compassionate attitude to individuals.
- 3.3 The inter-dependency of SADC countries and people, nowhere more evident than in the spread of HIV, demands equity and a shared approach to the challenges of HIV/AIDS. The Regional (SADC) nature and implications of the epidemic and the desire to harmonise national standards in dealing with HIV/AIDS motivate this Code.

4. SCOPE:

4.1 Subject to the provisions of the Labour Act (Act No 6 of 1992) this Code applies to:

- 4.1.1 all employees and prospective employees;
- 4.1.2 all workplace and contracts of employment;
- 4.1.3 all human resources practices forming part of policy component of any organization.

5. POLICY DEVELOPMENT AND IMPLEMENTATION:

5.1 As policy development and implementation is a dynamic process, this Code shall be:

- 5.1.1 communicated to all concerned;
- 5.1.2 routinely reviewed in the light of new epidemiological and scientific information;
- 5.1.3 monitored for its successful implementation and evaluated for its effectiveness in the workplace.

6. POLICY COMPONENTS:

6.1 Education, awareness and prevention:

- 6.1.1 Information, education and prevention programmes should be developed jointly by employers and employees and should be accessible to all at the workplace. Education on HIV/AIDS should, where possible, incorporate employee families.
- 6.1.2 Essential components of prevention programmes are information provision, education, prevention and management of sexual transmitted diseases (STD's), condom promotion and distribution and counselling on high risk behaviour. Workplace AIDS programmes should cooperate with and have access to resources of the National AIDS Programme.

6.2 Job Access:

There should be neither direct nor indirect pre-employment testing for HIV. Employees should be given the normal medical tests of current fitness for work and these tests should not include testing for HIV.

6.3 Workplace testing and confidentiality:

- 6.3.1 There should be no compulsory workplace testing for HIV. Voluntary testing for HIV on the request of the employee should be done by a suitably qualified person in a health facility with informed consent of the employee in accordance with normal medical ethical rules and with pre- and post-test counselling.
- 6.3.2 Persons with HIV/AIDS should have the legal right to confidentiality about their HIV status in any aspect of their employment. An employee is under no obligation to inform an employer of her/his HIV/AIDS status. Information regarding the HIV status of an employee should not be disclosed without the employee's written consent.
- 6.3.3 Confidentiality regarding all medical information of an employee or prospective employee should be maintained, unless disclosure is legally required. This applies also to health professionals under

contract to the employer, pension fund trustees and any other personnel who obtain such information in ways permitted by the law, ethics, the code or from the employee concerned.

6.4 Job Status:

HIV status should not be a factor in job status, promotion or transfer. Any changes in job status should be based on existing criteria of equality of opportunity, merit and capacity to perform the work to a satisfactory standard.

6.5 HIV Testing and Training:

In general, there should be no compulsory HIV testing for training. HIV testing for training should be governed by the principle of nondiscrimination between individuals with HIV infection and those without and between HIV/AIDS and other comparable health/medical conditions.

6.6 Managing Illness and Job Security:

- 6.6.1 No employee should be dismissed merely on the basis of HIV status, nor should HIV status influence retrenchment procedures.
- 6.6.2 Employees with HIV related illness should have access to medical treatment and should be entitled, without discrimination, to agreed existing sick leave provisions.
- 6.6.3 HIV infected employees should continue to work under normal conditions in their current employment for as long as they are medically fit to do so. When on medical grounds they cannot continue with normal employment, efforts should be made to offer them alternative employment without prejudice to their benefits. When an employee becomes too ill to perform his/her agreed functions, standard procedures for termination of service for comparable life-threatening conditions should apply without discrimination.

6.7 Occupational Benefits:

- 6.7.1 Government, employers and employee representatives should ensure that occupational benefits are nondiscriminatory and sustainable and provide support to all employees including those with HIV infection. Such occupational benefits schemes should make efforts to protect the rights and benefits of the dependants of deceased and retired employees.
- 6.7.2 Information from benefits schemes on the medical status of an employee should be kept confidential and should not be used by the employer or any other party to affect any other aspect of the employment contract or relationship.
- 6.7.3 Medical schemes and health benefits linked to employment should be nondiscriminatory. Private and public health financing mechanisms should provide standard benefits to all employees regardless of their HIV status.
- 6.7.4 Counselling and advisory services should be made available to inform all employees of their rights and benefits from medical aid, life insurance, pension and social security funds. This should include

information on intended changes to the structure, benefits and premiums to these funds.

6.8 Risk Management, First Aid and Compensation:

- 6.8.1 Where there may be an occupational risk of acquiring or transmitting HIV infection, appropriate precautionary measures should be taken to reduce such risk, including clear and accurate information and training on the hazards and procedures for safe work.
- 6.8.2 Employees who contract HIV infection during the course of their employment should follow standard compensation procedures and receive standard compensation benefits.
- 6.8.3 Under conditions where people move for work, government and organisations should lift restrictions to enable them to move with their families and dependents.
- 6.8.4 People who are in an occupation that requires routine travel in the course of their duties, should be provided with the means to minimise the risk of infection including information, condoms and adequate accommodation.

6.9 Protection Against Victimisation:

- 6.9.1 Persons affected by or believed to be affected by HIV or AIDS should be protected from stigmatisation and discrimination by co-workers, employers or clients. Information and education are essential to maintain the climate of mutual understanding necessary to ensure this protection.
- 6.9.2 Where employers and employees agree that there has been adequate information and education provisions for safe work, then disciplinary procedures should apply to persons who refuse to work with an employee with HIV/AIDS.

6.10 Grievance Handling:

- 6.10.1 Standard grievance handling procedures in organisations, in labour and civil law, that apply to all workers should apply to HIV related grievances. Personnel dealing with HIV related grievances should protect the confidentiality of the employee's medical information.

6.11 Information:

- 6.11.1 Government should collect, compile and analyse data on HIV/AIDS, sexually transmitted diseases and make it available in the public domain. Stakeholders should cooperate in making available national data for monitoring and planning an effective response to the Regional health, human resource, economic and social impact of the AIDS epidemic.

6.12 Monitoring and Review:

- 6.12.1 Responsibility for monitoring and review of the Code and its implementation should lie with the parties to the tripartite Labour Advisory Council and with the Ministry of Labour.

Appendix C: The Zimbabwean Code⁶⁸

Statutory Instrument 202 of 1998

Labour Relations (HIV and AIDS) Regulations, 1998

ARRANGEMENT OF SECTIONS

Section:

1. Title.
2. Interpretation.
3. Education of employees on HIV and AIDS.
4. Medical testing on recruitment.
5. Testing of employees for HIV and confidentiality.
6. Job status and training.
7. Eligibility for employee benefits.
8. Sick and compassionate leave.
9. HIV risk management.
10. Copy of regulations for each employee.
11. Offence and penalty.

It is hereby notified that the Minister of Public Service, Labour and Social Welfare, in terms of section 17 of the Labour Relations Act (Chapter 28:01), has made the following regulations:

TITLE:

1. These regulations may be cited as the Labour Relations (HIV and AIDS) Regulations, 1998.

INTERPRETATION:

2. In these regulations -
 “AIDS” means acquired immuno-deficiency syndrome and includes the AIDS-related complex;
 “HIV” means human immuno-deficiency virus;
 “testing”, in relation to HIV, includes -

⁶⁸ This Code applies only to nongovernmental employers and employees.

- (a) any direct analysis of the blood or other body fluid of a person to determine the presence of HIV or antibodies to HIV; or
- (b) any indirect method, other than the testing of blood or other body fluid, through which an inference is made as to the presence of HIV;

“related communicable disease” means any communicable disease whose transmission may be linked with HIV due to its transmission through body fluids or whose risk of clinical disease may be increased due to the presence of HIV;

“medical practitioner” means a person registered as a medical practitioner in terms of the Medical, Dental and Allied Professions Act [Chapter 27:08].

EDUCATION OF EMPLOYEES ON HIV AND AIDS:

3. 1. Every employer shall cause to be provided for the benefit of every person employed by him, and at such place and time during normal working hours as he may appoint, education and information relating to -
 - (a) the promotion of safe sex and risk-reducing measures in relation to sexually transmitted diseases; and
 - (b) the acquiring and transmission of HIV; and
 - (c) the prevention of the spread of HIV and AIDS; and
 - (d) counselling facilities for HIV and AIDS patients.
2. Education and information shall be provided in terms of sub-section (1) by persons who have proven sound knowledge and expertise in matters relating to HIV and AIDS, and who are able to communicate information with consistency and accuracy.
3. The design of the education programmes shall be in accordance with guidelines approved by the relevant employer and employee organizations, in consultation with the Ministry of Health and Child Welfare and any other organization with expertise in HIV and AIDS-related matters.
4. The provision of the education referred to in sub-section (1) shall be at such intervals as the relevant employer and employee organizations may agree.

MEDICAL TESTING ON RECRUITMENT:

4. 1. No employer shall require, whether directly or indirectly, any person to undergo any form of testing for HIV as a pre-condition to the offer of employment.
2. Sub-section (1) shall not prevent the medical testing of persons for fitness for work as a pre-condition to the offer of employment.

TESTING OF EMPLOYEES FOR HIV AND CONFIDENTIALITY:

5. 1. It shall not be compulsory for any employee to undergo, directly or indirectly, any testing for HIV.

2. No employer shall require any employee, and it shall not be compulsory for any employee, to disclose, in respect of any matter whatsoever in connection with his employment, his HIV status.
3. No person shall, except with the written consent of the employee to whom the information relates, disclose any information relating to the HIV status of any employee acquired by that person in the course of his duties unless the information is required to be disclosed in terms of any other law.

JOB STATUS AND TRAINING:

6.
 1. No employer shall terminate the employment of an employee on the grounds of that employee's HIV status alone.
 2. No employee shall be prejudiced in relation to:
 - (a) promotion; or
 - (b) transfer; or
 - (c) subject to any other law to the contrary, any training or other employee development programme; or
 - (d) status;or in any other way be discriminated against on the grounds of his HIV status alone.

ELIGIBILITY FOR EMPLOYEE BENEFITS:

7.
 1. Subject to any other law to the contrary, the HIV status of an employee shall not affect his eligibility for any occupational or other benefit schemes provided for employees.
 2. Where in terms of any law the eligibility of a person for any occupational or other benefit scheme is conditional upon an HIV or AIDS test, the conditions attaching to HIV and AIDS shall be the same as those applicable in respect of comparable life-threatening illnesses.
 3. Where any HIV testing is necessary in terms of sub-section 2, the employer shall ensure that the employee undergoes appropriate pre-and post-HIV test counselling.
 4. Where an employee who opts not to undergo an HIV testing for the purposes of sub-section 2, no inferences concerning the HIV status of the employee may be drawn from such exercise by the employee of the option not to undergo the testing.
 5. Where an employee undergoes an HIV testing for the purposes of sub-section 2, the employer shall not, unless the occupational or other benefit scheme concerned is operated by the employer, be entitled to information concerning the HIV status of the employee concerned.

SICK AND COMPASSIONATE LEAVE:

8. Any employee suffering from HIV or AIDS shall be subject to the same conditions relating to sick leave as those applicable to any other employee in terms of the Act.

9.
 1. Where a person is employed in an occupation or is required to provide services where there may be a risk of transmitting or acquiring HIV or AIDS, the employer shall provide appropriate training, together with clear and accurate information and guidelines on minimising the hazards of the spread of HIV or AIDS and related communicable diseases.
 2. The working conditions and procedures in relation to occupations referred to in sub-section 1 shall be designed to ensure optimal hygienic precautions to prevent the spread of HIV or AIDS and related communicable diseases to employees and members of the public.
 3. Personal protective devices shall be issued, free of charge, by the employer to persons employed in occupations referred to in sub-section 1.
 4. The employer shall cause to be reviewed, for safety and efficacy, the use of any equipment, devices, procedures, including first-aid procedures used, or guidelines followed, in any occupation referred to in sub-section 1.

COPY OF REGULATIONS FOR EACH EMPLOYEE:

10. An employer shall provide every employee with a copy of these regulations.

OFFENCE AND PENALTY:

11. Any person who contravenes any provision of these regulations shall be guilty of an offence and liable to a fine not exceeding five thousand dollars or to imprisonment for a period not exceeding six months or to both such fine and such imprisonment.

Supplement to the Zimbabwean Government Gazette dated the 14th August 1998. Printed by the Government Printer, Harare, Zimbabwe.

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The Joint United Nations Programme on HIV/AIDS (UNAIDS) is the leading advocate for global action on HIV/AIDS. It brings together seven UN agencies in a common effort to fight the epidemic: the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations International Drug Control Programme (UNDCP), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO) and the World Bank.

UNAIDS both mobilizes the responses to the epidemic of its seven cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV on all fronts: medical, public health, social, economic, cultural, political and human rights. UNAIDS works with a broad range of partners – governmental and NGO, business, scientific and lay – to share knowledge, skills and best practice across boundaries.



Joint United Nations Programme on HIV/AIDS

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